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THE GRIEF THERAPIST AS A PERSON

by

SANDRA JOAN DMYTRASH ©

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
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IN
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The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE GRIEF THERAPIST AS A PERSON submitted by SANDRA JOAN DMYTRASH in partial fulfilment of the requirements for the degree of MASTER OF EDUCATION IN COUNSELLING PSYCHOLOGY.

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Date: October 7, 1992

DEDICATION

In memory of my father, John Dmytrash,

whose love always sustained me.

ABSTRACT

Research into grief therapy has provided valuable insights about the process of grief and mourning in relation to the concerns of the griever. One neglected aspect of grief therapy research relates to the grief therapist. This study focused on the grief therapist in an attempt to answer the question: "Who is the grief therapist as a person?" Using grounded theory design, five grief therapists were interviewed, and the transcripts analyzed using the constant comparative approach. The study focused on the grief therapist's view of him or herself, and identified what events the therapist senses have served as significant markers in their development as a person. The results indicated that the grief therapist's sense of self can be thought of as three distinct aspects: an acquired self, influenced by external events such as childhood experiences and various critical incidents; an integrated self, dominated by internal processes such as personality characteristics and personal values; and finally an emerging self that is highlighted by the use of the self in the interaction with the patient, and often characterized by self-disclosures, or of internally relating the patient's experiences to one's own life.

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CHAPTER I

INTRODUCTION

Studies in grief therapy have yielded many important insights about the meaning and the experience of grief. Research has explored a variety of aspects of grief, some of which include the significance of attachment and loss (Bowlby, 1980), stages of normal and abnormal grief reaction (Lindemann, 1944), strategies that facilitate grief therapy (Kubler-Ross, 1969), and the differentiation between various kinds of losses (Parkes, 1980). Most studies thus far, focus on the experience of the griever. What has not been explored however is the therapist as a person. Thus this study will attempt to address the question of "who is the grief therapist?"

Grief, a highly emotional issue and a common human occurrence, logically impacts both the patient and the therapist. Assuming that an important emotional interaction occurs between the therapist and the patient, it is important to recognize and to examine the therapist's personal experiences, reactions, feelings, and impressions, which may be just as significant as those of the patient. Only then can an appreciation be gained of the internal processes that take place for the therapist, both professionally and personally.

It is evident from the interviews in this study that in order to arrive at an understanding of the grief therapist as a person, one must go beyond merely examining the credentials, experience, and expertise of these individuals as clinicians alone. Each individual's personal background, personality, choices regarding theoretical orientations, developmental highlights in their life, and personal relationships appear to contribute largely to their unique development as a person and as a therapist. It is hoped that through examining the lives of five individuals who have exemplified their expertise and interest in the area of grief therapy, a better understanding will take place concerning who the grief therapist is as a person. This will include examining what has influenced them to choose grief therapy as a special area of interest in their careers, what skills they have developed and utilized in their work, what personal qualities they possess, as well as what experiences have contributed most to their personal development.

The study attempts to capture some of the highlights these therapists point to as influencing their development as both a therapist and as a person. It also offers an opportunity to become intimately acquainted with these individuals through their numerous self-disclosures, and therefore offers very personal snap-shots of their lives. Throughout these interviews, the therapists will discuss many diverse topics which are significant to them, covering such areas as their views about their self-concept, strengths and shortcomings, childhood influences, family backgrounds, interpersonal relationships, philosophies about their view of death and dying, and various critical incidents in their life which have affected them personally. A unique picture of each therapist emerges from their discussions. That picture points in the direction of unfolding a process that describes the most salient influences in the therapist's life which has most contributed to their development both personally and professionally. Ultimately, that understanding may hopefully lead to a better appreciation of persons in the profession, and contribute to greater insights about preparation for pursuing grief therapy as a profession.

Significance of the Study

Becoming better acquainted with the grief therapist as a person is important for several reasons. By arriving at a better understanding of the experience of grief therapists, it may then be possible to appreciate what experiences are influential in the development of a grief therapist, and what personal qualities are beneficial or perhaps even essential in conducting grief therapy. Ultimately, in coming to better understand the person, we may come to better appreciate their skills and the process of grief therapy, how the therapists utilize their various theoretical backgrounds, and how they make interventions according to their knowledge, preferences and personal characteristics. It is hoped that as therapists reflect upon their lives and become increasingly more self-aware and sensitive to their own unique experiences, they may be increasingly able to serve, understand, and assist their patients toward change.

This study offers an opportunity for broadening our awareness of personal and therapeutic experiences in grief therapy. This study also has implications toward the training, preparation, and education of grief therapists, providing needed information to prospective therapists about what personal characteristics and experiences can assist or even be essential in grief therapy. Furthermore, by realizing the significance of a therapist's personal losses, stresses, emotional ties, and possible countertransference issues arising out of the grief therapy setting, this study possibly adds to a greater understanding of the process and emotional components of therapy and therapists in general.

Studies into grief issues and particularly the grief therapist are especially timely in our present society as we face an ever-increasing aging population; it is likely that the services of grief therapists will continue to increase as more sectors of society are affected by grief issues and people reach out for assistance. Information about grief therapists may also have implications to other caregivers working areas of therapy, such as in religious organizations, parenting, and education. Thus, as we explore the various dimensions of the grief therapists' life, how their individual personal issues and experiences can interfere with or enhance their professional role, we can hopefully better appreciate the impact and the range of emotions that arise in grief therapy, and ultimately promote heightened self-awareness for all those in helping professions.

Definition of Terms

Grief therapist - a professional who has displayed interest and expertise in working with patients with grief issues, either in an individual or a group setting.

The life story - the patient's description of significant events, particularly regarding their losses.

Critical incidents - developmental highlights that have affected the individual in a profound way.

Countertransference - reactions and feelings elicited by the patient in the therapist, often pointing toward the therapist's unresolved issues.

Neutrality - a therapeutic position, whereby the therapist remains open to all aspects of the patient's personality and thereby maintains a balance stance.

Self-disclosure - personal revelations, both negative and positive, by the therapist about personal feelings or experiences.

CHAPTER II

LITERATURE REVIEW

The Therapist as a Person

Freud (1912) believed that the therapists' personality was of critical importance in the therapy endeavour. He writes, "It is not a modern dictum, but an old saying of physicians that these diseases are not cured by the drug, but by the physician" (p. 111). Many writers have since pointed out that while Freud may have emphasized the importance of the analyst's emotional neutrality, in practice he revealed he was far from as neutral as he prescribed. Similarly, Carl Jung (1961) writes, "It is in fact largely immaterial what short of techniques the therapist uses, for the point is not the technique but the person who uses the technique . . . the personality and attitude of the doctor are of supreme importance" (p. 45). More recently, the psychoanalyst, Harry Guntrip (1961) emphasizes a similar idea in his statement that the therapist must be "a real person, a therapeutic good object, and that the technique for the psychoanalyst itself does not constitute the cure" (p. 128). Similarly, McConnaughy (1987) points to a wealth of clinical and theoretical studies which verify that the character and interpersonal style of the therapist determines the nature of the therapy offered, that actual techniques employed are of lesser importance than the therapists' unique personality, and that the therapists tend to select techniques to work from, precisely which suit their personality. It is clear, then, that the tradition of psychotherapy is rooted in an appreciation of the therapist as a person. Surprisingly then, judging from the crucial awareness of the impact of the therapist's personal qualities in the therapeutic relationship, to date, the literature which explores therapists in general, and grief therapists in particularly, remains relatively limited.

This review of the literature which focuses on identifying features that help in coming to an understanding of the humanness of the therapist, will involve several phases. Firstly, as no studies thus far have exactly addressed an understanding of the grief therapist as a person, an attempt will be made to highlight some of the studies which have focused on the characteristics therapists in general share, in an effort to incorporate some of these insights into an understanding of grief therapists. A second section will focus on the personal grief experiences of therapists. The intention is that hopefully by examining the various experiences therapists have written about regarding their personal losses, an appreciation can be achieved regarding individuals who choose to work in the area of grief therapy.

Much of the modern literature since the time of Freud emphasizes the necessity for the therapist to appreciate and display his/her humanness. Rollo May (1983) points out that the therapist must recognize that both he/she and the patient are human beings, suffering from anxiety and despair, and that "the difference between the therapist and patient has to do more with the situation which brings the patient there and less than it does the supposition that one person is luckier in his life than the other" (p. 120). Similarly Greenson (1971) emphasizes the necessity that the therapist has the capacity of intimate knowledge about himself or herself, and to interact with his/her patients as fellow human beings. He refers to the "real relationship" which coexists with that of the transference or therapy relationship. Bonime (1982), writing about this personal reflections after 40 years as an analyst, highlights the importance of collaboration between the therapist and patient, for as he points out, it is the interpersonal experience which is itself curative. Similarly, Anna Freud (1954) writes, "With due respect to the necessary handling and interpretation of the transference, I feel still that we should leave room somewhere for the realization that analyst and patient are also two people of equal adult status, in a real relationships to each other" (p. 618). The implication is that the more a therapist accepts and values themself, the more effective they can be in helping their patients.

Therapists often emphasize the necessity that they be self-aware. Chessick (1990) argues for the use of "self-analysis" for therapists in order to understand oneself better, to better work within the therapeutic process and to improve one's sense of autonomy and well-being. He refers to the fact that themes of death and loss repeatedly came up for him personally, as his children grew to adulthood. He actually argues for a methodical self-analysis which is separate and apart from the traditional analysis of countertransference reactions.

Much has been written about the importance of recognizing the personal qualities of the therapist. Chrzanowski (1989) emphasizes that the individual personality of the analyst is an integral aspect influencing the analytic situation; in clinical practice patients do not project onto a blank screen but rather onto a person whose way of listening contributes to the therapeutic effect. Craig (1986) reminds therapists of the importance of being able to use themselves and speaks about the analyst Donald Winnicott and his ability "to be at one with his own self that enabled him to radically transcend that self in order to be with and for the other" (p. 23). Basescu (1987) brings attention to the importance of recognizing that therapists may have doubts, perhaps about what to do, or think, or say, or not say. He asserts that it is the "quest for certainty" that impedes the search for meaning, and that once a therapist accepts uncertainty, it's presence need not be as debilitating. In fact, he says he has serious doubts about psychoanalysts who say they have no doubts about what they are doing.

Paolino (1982) maintains that the best therapist is one who prides himself/herself on technical flexibility, the capacity to be childish, or to liberate oneself from the confines of the intellect, and to deeply experience within his or her own psychological self the intensity of feelings and excitement that are generated within the therapeutic relationship. He also points to the capacity for psychological mindedness, insight to perceive the relationship between thought and feelings and action, a capacity to learn, and to direct inwards. He too emphasizes how the therapist must be "human," always remembering that they and their patients are real people interacting in a real situation.

Tremblay, Herron and Schultz (1986) found that there appears to be a "therapist personality" that spans theoretical orientations; it comprises a focus on the present, strong self-acceptance, and self-regard. Stern (1985) refers to the necessity of the analyst to have qualities which include curiosity, receptivity, and tolerance of ambiguity, uncertainty, and sometimes pain. He refers to other studies which indicate that the most salient characteristics of the therapist is expertness, trustworthiness, attractiveness and credibility. His studies also conclude that a therapist's well-being, flexibility, genuineness, respectfulness, and ability to deal effectively with affect are the most valued qualities, as they reflect the therapist's well-being, sense of self, interpersonal comfort, and skill. Similar findings have been highlight by Costanzo and Philpott (1986). Marmor (1977) points out that there is no single personality structure or motivations that create a psychoanalyst, but that many tend to be liberal, interested in artistic and cultural pursuits, and clearly indicate a basic humanistic approach in their thinking.

Hollander-Goldfein, Fosshage and Bahr (1989) in their study of patient choices of therapists found that the traits considered most important for therapists to possess were: to be likeable as people, competent, understanding, and more of the qualities patients wish to emulate. Likewise, therapists tended to like and to express a stronger desire to work with patients who ultimately chose them, and so a reciprocity of perceptions and attraction appears to occur in the therapeutic dyad. Irwin (1986) points to the "therapist personality" as an in depth knowledge of how and why people operate as they do, in addition to technique, intellect, creativity, and emotional maturity. McClure Goulding and McClendon (1989) describe the "natural" for doing psychotherapy as "bright, dedicated, hardworking, and successful, who early on made a decision to be self-reliant" (p. 33). Paolino (1982) points out that the factors he emphasizes as essential for the psychotherapist is their ability to employ a connectedness or intuitive empathy or a sense of "being with the patient" (p. 11). He describes it as follows: the capacity of the therapist to reach down into his/her intimate inner self and to listen with his/her own full mental and physical being in order to fully grasp and share the message that the patient is trying to communicate.

There is research to show that the individual therapist has a substantial effect on process and outcome of therapy. Lambert (1989) challenges clinicians to begin to accumulate data on their own experience in therapy. Therapists have also been encouraged to recognize the stress inherent in their work while engaging oneself in the life of another person (Otto, 1979), and to become aware of the conflicts and unconscious defenses while working with patients (Marmor, 1977); to examine their motivation to help, as well as their personal needs, such as the need to give advice, reassurance, and information (Crowley, 1962).

One of the most intriguing aspects that several writers point to is that, through the interaction in therapy, both the patient and the therapist are changed (May, 1983). What is the nature of this change? Irwin (1986) addresses some of the alterations in personality that may occur: she specifies the importance of learning as a therapist, for listening to oneself, and the fundamental requirement for a therapist to have the capacity to invest in others, and the motivation to try to understand who they are first in order to help others. She also identifies areas where therapists may have difficulty wishing to rescue, entering a helping profession or in order to deny death, and thereby trying to control one's sense of helplessness. Erich Fromm (1991) argues that there is no better analyses for analysts than analyzing people, because it is through this process that the analyst may be touched as he/she attempts to experience what the patient experiences. He challenges analysts to not lack for compassion, "because one has a deep feeling that nothing that happens to the patient is not also happening to oneself" (p. 600). Gill (1983) emphasizes that the interpersonal interaction between therapist and patient stems from the tenets of Freud who pointed out that the practising analyst should always be aware of his active conflicts,and that the nature of his work will stir up these conflicts.

Becoming a psychotherapist requires more than becoming capable of dealing with the demands of the work. It also appears to be part of being secure within oneself, and using the self spontaneously in relation to the patient. Eckler-Hart (1987) discusses the emergence of the therapist's true self and the false self which may also arise when there is anxiety about the vulnerabilities of one's true self; he challenges psychotherapy trainees to clearly distinguish their "therapist selves" and their "personal selves" and points out that the struggle to bring the true self into the domain of psychotherapy is a career-long endeavour.

The importance of having undergone one's own therapy is often highlighted as a necessity for therapists to experience. Studies (MacDevitt, 1987; Prochaska & Norcross, 1983) have indicated that 80% of therapists have had personal therapy and highly value these experiences as preparation for providing therapy to others. Irwin (1986) points out, "perhaps it is only in one's patienthood that one can come to intimately know the longings, yearning, jealousies, and rages that clamour within, as well as the anxieties, depression and guilt that such impulses stimulate" (p. 193). It appears that only when one can be seen to tolerate one's own conflicting wishes, needs, and impulses, that it can be possible to help another with similar issues. Likewise, Schlesinger Silver (1982) claims that while nowhere is it required that therapists be "perfectly analyzed," they are required to have a deep commitment to the development of the self in order to function as therapists. The emphasis by these authors seems to be on the necessity for therapists to be able to scrutinize themselves both inside and outside of the therapy domain, and thereby utilize their self-awareness in their work.

Countertransference

McClure and Hodge (1987) discuss the centrality of countertransference in the therapist/patient relationship, and outline the two schools of thought: The classicists define it as the therapist's unconscious reactions toward the client; the totalists expand the definition to include all conscious and unconscious feelings the therapist may have toward the client, and adherents to this approach point to the benefits to the client, by using countertransference to self-disclose (Little, 1967), and acknowledge feelings (Greenson, 1974). A more recent third conception of countertransference is in conceiving countertransference as including both negative and positive aspects of the therapeutic relationship (Blanck & Blanck, 1979), where countertransference is thought of as a reflection of blind spots in the analyst of his own unconscious infantile needs, but also seen as a means of understanding the patient's communications, by analyzing one's affective reaction to them. Blanck and Blanck point out that new therapy technique involves the therapist "navigating into unchartered areas of his/her own personalities" (p. 125), thereby focusing on the engagement and interaction between him/herself and the patient.

In his study of the impact of the analysts' personality on treatment, Tuttman (1982) concludes that analysts differ in their capacity to deal with their own unconscious drives, which are more or less likely to be aroused when working with patients. He states, "each has a hidden, personal reservoir of archaic internalized, part-self and part-object representations which are awakened in the treatment interaction. Personality factors determine the extent to which the analysts' primitive impulses and affects will be reawakened and expressed regressively" (p. 25). He explains that this involves the analyst being able to vacillate between empathy and objectivity, to have the capacity to temporarily loosen and cross boundaries between self and other, to sense when to assert individual apartness, and to appreciate the space between the self and other. Similarly, Paolino (1982) maintains that engaging in a relationship that lacks the human side of the therapist, is depriving the patient of a meaningful interpersonal relationship from which the patient can psychically grow.

Hoffman (1983) similarly concludes: the therapist's analytic task, his tendency toward understanding on the one hand, and his countertransference reaction on the other, often creates a sense of real conflict as part of his total experience of the relationship. He asserts that this conflict is invariably a part of what the patient senses about their therapist's response, and that the patient may come to understand that the analyst's experience is not less complex than his own. Likewise, Lindner (1984) presenting an analysis of the transference and the countertransference factors in both patient and therapist arising out of a life-threatening crisis in the life of the therapist, concludes the following:

> If this writer learned anything from his experiences with both the "event" and the various patient reactions to it and to him, it was that, as always, there is one preeminent therapeutic tool: that tool is the therapist's

> unswerving concentration on his own countertransference feelings while simultaneously keeping in touch with the pulsations of the transference feelings which motivate those who seek his professional skills. It is this which permits therapeutic collaborations to succeed. In this way, growth and integration are most meaningfully achieved for both participants in the dyad known as psychotherapy. (p. 78)

A similar point is made by Goldberg (1986), who maintains that the practitioner's vulnerability, emanating from his/her subjective experiences, is not necessarily a disability in practising psychotherapy. In fact, "the practitioner's responsive vulnerability is the basis of his/her sensitivity, compassion, and responsiveness to others' suffering, while at the same time, potentially, a wound which may become exacerbated by excessive painful stress and self-doubts" (p. 33).

Norcross and Prochaska (1986) in their study of psychological distress and self-change in therapists, emphasize that therapists have problems in their life like everyone else. They found that loss is the central feature of most events surrounding distress, including death, marital separation, serious illnesses, major material losses, and changes of residences. The most frequent precipitant of psychological distress was of relationship problems, which include familial death and illness, or disruptions in interpersonal relationships. They also point out that few studies have systematically investigated the person of the psychotherapist outside his or her professional world. Even the effects of therapist's personal characteristics are evaluated for their influence on clinical practice, rather than for their influence on the total person. Their study found that no significant differences were observed among psychotherapists coping due to theoretical orientation, personal therapy, or clinical experience. In a second study, Norcross et al. (1986) emphasized how human beings have an ability to withstand personal loss and tragedy successfully. Despite serious setbacks such as the death of a family member or a tragic personal illness, the majority of people achieve a quality of life equivalent to or even exceeding their prior level. This implies that experiencing various traumatic experiences and losses in life can actually help enhance character and personal growth for the individual.

Losses in the Lives of Therapists

Grief therapy has been regarded by some as a particularly challenging area, beset with a number of potential countertransference issues, feelings of helplessness, and the probability of the patient's experiences triggering one's own losses (Lamb, 1988; Worden, 1982). Furthermore, it has been pointed out (Weinberg, 1988; Abend, 1982) that the lack of research on the therapist's feelings about his own death, is partly because it is such a painful topic to confront that it invites denial, and partly because of the fact that many people may not find it so easy to bare their souls. Freud in 1915, stated the same idea eloquently:

> To anyone who has listened to us we were of course prepared to maintain that death was the necessary outcome of life, that everyone owes nature a death and must expect to pay the debt–in short, that death was natural, undeniable and unavoidable. In reality, however, we were accustomed to behave as if it were otherwise. We showed an unmistakable tendency to put death to one side, to eliminate it from life. We tried to hush it up. It is indeed impossible to imagine our own death; and whenever we attempt to do so we can perceive that we are in fact still present as spectators. Hence the psychoanalytic school should venture on the assertion that at the bottom no one believes in his own death or, to put the same thing another way, that in the unconscious everyone of us is convinced of his own immortality. (p. 289)

Some attempts have been made by therapists to confront issues of loss in their life. Eissler (1977) discusses the negative effect of his aging on his patients; Engle (1975) writes about his personal feelings over the loss of his twin. Guy and Souder (1986) offer insights about the impact of a therapist's illness or accident on the psychotherapy practice. Little (1967) describes the transference and countertransference and survival reactions following a heart attack. Lewis (1982) discusses his feelings of helplessness and intense defenses as he underwent discussions with four dying friends. Spiegal and Glafkides (1983) address the effects of death and dying as an issue in a therapy group. Chernin (1976) describes his use of omnipotence as an unconscious defense mechanism in reaction to his own acute illness. The paucity of reports generally, however, can be regarded as an expression of avoidance and denial that is invoked by practitioners when faced with the anxiety, guilt, and vulnerability that accompany incapacitating illness (Schwartz, 1987). The following section will be an attempt to discuss the experiences of various therapists who have had the courage to write about their personal experiences of handling life-threatening illness, and in some cases death.

Dewald (1982) was one of the first therapists to use his own experience with serious illness and to consider some of the reactions and feelings this issue stimulated in his patients. He argued that providing the patient with detailed information about one's illness may interfere with the subsequent evolution, analysis, and working through of the patient's unconscious fantasies and reactions to the therapist's illness. He also found that the meaning of his illness for the patients depended on their earlier life experiences, and he chose in practice to vary the amount of factual information he gave to patients. A similar conclusion was arrived at by Flapan (1986) who found that the meaning of her illness for each patient depended on the person's earlier life experiences, the working relationship the patient had with her, the transference feelings and the current situation in the person's life. Weinberg (1988) in her account of her illness, argues that protecting oneself can only be done by the fullest understanding of the transference, and she offers examples where she became hypersensitive to her patients' moods, reactions, and transferential feelings and used them, as a result of her experience with a chronic illness. Ultimately, she says her brush with death sensitized her not only to illness and death, but to the importance of competence and self-determination, and significantly, to life itself.

Lasky (1990) maintains that it is important to try to preserve as much neutrality as possible in the therapeutic relationship, and argues for the view of giving as little factual information to patients about the therapist's illness as possible. He prefers to give the greatest amount of freedom one can to permit the imagination and fantasy to do their work, and his emphasis is on eliciting the transferential components of the meaning of the experience for the patient.

Schwartz (1987) on the other hand discusses his own illness in great depth, pointing out the parallel between his own feelings and the panic proportions he felt for his patients and his overidentification with them, as well as how the experience harkened back to the feelings of abandonment after his own analyst died, reawakening feelings of grief, loss and guilt. He also argues for the usefulness of attempting to keep analytic neutrality in order for the true depth and unique unconscious fantasies to arise and be worked through in the patient. In a similar vein, Van Dam (1985) describes an example of acting out transference during his own brief illness and hospitalization, and how it reappeared in a particular patient's transference. He also challenges the therapist to analyze his/her awareness of regression within himself/herself, which may in turn strengthen the capacity to relate to the patient appropriately.

Shapiro (1985) discusses how the death of a significant person in the analyst's life affected the treatment of a severely regressed patient. He concludes that the analysts' self-absorption while coping with loss helped to create an atmosphere apparently parallel to the patient's early life. Thus, an opportunity was made available to work through resistances for both the patient and analyst.

Some have pointed to the fact that therapists themselves are often "wounded healers" (Groesbeck & Taylor, 1977); psychologically not only do patients have a 'physician' or inner healer within themselves, but they argue there is also a 'patient' in the doctor. They challenge the physician to be in touch again and again with their own wounds or 'internal patient' so that the patient can connect with their own healing power or 'inner physician.' In essence, both participants must experience the health-sickness polarity if the patient is to be freed. Unfortunately, the physician all too often can only identify with the healer aspect and projects his inner wounds and illness onto the patient. These writers emphasize that anyone who does psychotherapy must be specially prepared to have his or her own inner wounds activated and reactivated time and again as they participate in the healing process with the patient. The therapist will not be able to stand outside the experience as a disinterested observer, or orchestrator of method. He/she must be ready to be analyzed and reanalyzed with the patient again and again. As well, the therapist is also in a position to help the patient bring meaning to his illness, and understanding to his part in the illness and the healing experience.

While research has often focused on the importance of the therapist's self-awareness and ability to remain open to examining their issues, it appears that grief issues in themselves may be viewed as offering a special opportunity for introspection. Yalom and Lieberman (1991) in their study of bereavement and heightened existential awareness, found that existentially aware spouses were able to look into, rather than away, from death. They were not as prone to being fixated on their losses, and while they did have more anxiety and depression, they found the dysphoria linked not so much to brief, as to an awareness of their own death.

A special kind of loss, the loss of one's therapist, has drawn some recent attention in the literature, and will be focused upon here, the significance of which will be apparent later in this study. Several studies have addressed this important reality (Gurtman, 1990; Kaplan & Rothman, 1986; Rosner, 1986; Meloche, 1984; Pruyser, 1984; Schlesinger Silver, 1982; and Givelber & Simon, 1981). In one study of the patient's reactions to the death of the psychoanalyst (Lord, Ritvo & Solnit, 1978), it was confirmed that the patient's mourning process does not derive solely from the unresolved transference relations to the therapist. It is also significantly based on the loss of the therapist experienced as a human being in their own right. Specifically, this study found that early loss and deprivation appear to be the most important factors associated with pathological mourning reactions, and it appears that the role of the analyst is one through which intensely felt relationships may be relived. With the death of the analyst, a powerful paradox takes place, "the 'omnipotent rescuer' perhaps uniquely equipped to assist with a crisis of such magnitude, not only can never do so again, but is indeed its cause" (p. 196).

Simon (1990) offers a personal account about her own therapist's heart attack and the wait over her recovery. She explains how the experience served to heighten her sensitivity to her patients and their relationships with her. She identified various stages to her grief experience: the initial period included experiencing emotions such as compassion, anger, loss, and fear. Denial continued to be the dominant emotion; an uncomfortable feeling of missing someone; and fantasized conversations with them and an overall desire to simply connect. She also points out that she was reminded of important deaths in her own life, and had numerous dreams where the theme was loss and searching. The middle period was marked by feelings reflected in anger and loss, about the illness occurring, and the lack of clear information about the recovery. Upon her therapist's return, it was critical that she felt free to discuss her reaction to the illness. She also indicates that her therapist openly shared the medical information and disclosed some of his personal issues that arose from the crisis. This detailed information regarding his total condition was necessary for her to trust his relative permanence; his self-disclosure served to re-establish the context for psychotherapy. From the entire experience, the author offers the following recommendations to therapists: patients should be specifically told who they can call for further information and for assistance; patients should be contacted midway during the break and briefly informed of the therapist's progress and confirm or correct the anticipated date of return; therapists should handle crisis in a manner consistent with their theoretical orientations and with respect for their real relationship with their patient. She also challenges therapists to think about this subject and clarify their viewpoints and plans in order to be prepared if confronted with a personal crisis that unavoidably impacts their work.

A therapist (Goldberg, 1984), writing about her experience with cancer, found that when she compared the reactions of her individual patients with the group therapy situation, it was evident that the group appeared to be more conducive than individual therapy in encouraging people to express their feelings and fantasies. The knowledge that their feelings were shared by others helped them to be more accepting of their emotions. The therapist also found that in those instances when she shared openly her reactions, an intimacy developed far surpassing anything she had experienced previously in her work. "People grasped the humanness of the situation and banded together to lend help and support to one another and to me in performing the hard task of saying good-buy" (p. 296). Van Raalt (1984) found that subjects who experienced the sudden death of their analyst had more complicated, and prolonged anger reactions than those experiencing the death following a long-standing illness. Barbanel (1989) indicates that after the death of the psychoanalyst, many subjects reported that in some way their attachment to the second analyst was not as strong, and that there was a tendency for one analyst to become the good analyst and the other the bad analyst. Furthermore, Ziman-Tobin (1989) argues for the necessity of a "bridging" function to occur after an analyst dies, in order to work through some of the aspects of the loss, and Simon (1989) writes about her experience working as a "bridge" analyst in order to allow the patient time to mourn with another.

Tallmer (1989) states that the impending death of an analyst and it's associated fear and fantasies can be used as grist for the psychoanalytic mill. An analyst who is seriously ill or dying may easily feel a sense of guilt for deserting his patients, who have been encouraged to develop a trusting relationship; if the analyst has overidentified with the patient, or has separation issues to deal with, guilt may be exacerbated, as well as the need to avoid the issue altogether. It is important, however, to realize that patients prior to learning about the reality of their therapist's illness, frequently observe objective alterations in physical appearance and behavior. Tallmer points out that the more the analyst keeps reality a secret, preserving anonymity, the greater the arena for possible fantasies. She urges, as Eissler (1977), to forgo heroics, and instead strive to be a satisfactory and authentic role model to the patient. She notes that Freud himself was a rather poor role model, in this respect, for despite his theoretical position, he maintained an heroic stance throughout a long, suffering, and terminal illness, and evidently without discussing this with his patients.

Halpert (1982) describes a case where the analyst's denial of his own illness led to his avoiding the patient's association to his obvious symptoms, and continuing to treat the patient until he could barely breath. By this, he did not permit her to recognize and work through the issues that his illness stirred up in her. Halpert indicates that in such circumstances, the analyst's interest in the patient and his ability to maintain neutrality, objectivity, and empathy are significantly impaired. It is important to recognize that when the analyst denies his own illness, then the patient denies it also. Patients use denial not only in response to their guilt over their own aggressive wishes toward the analyst, but also in response to their perception that the analyst cannot tolerate awareness of his illness.

Shwed (1980) describes the reactions to the sudden and unexpected death of a psychiatrist, where the grief patterns included denial, feelings of abandonment, anger and eventual acceptance. He found than an unexpected intensity of smouldering anger and resentment of the patient's relatives and close friends were elicited toward the deceased psychiatrist, especially when the patient's grief was intense and prolonged.

It is evident from this literature review that therapists are influenced by various losses. Most conclusions point to encouraging therapists to not only recognize the significance of various personal losses on their life, but to use their personal insights in how they subsequently work with and relate to their patients.

CHAPTER III

METHODOLOGY

Grounded Theory

The term "grounded theory" was first used to designate a qualitative research method used for generating theory "from data systematically obtained from social research" (Glaser & Strauss, 1967, p. 2). Thus grounded theory is generating theory that follows from data, rather than precedes data. The intellectual roots of grounded theory, explained by Bowers (1988) stems from symbolic interactionism, which is a departure from the concept of functionalism and its notion of society as ordered, unified, and a naturally evolving whole.

Symbolic interactionists focus on the acting individual rather than the social system; the direction of analysis is from the individual toward the group or system, rather than from the system down to the individual role. It also maintains that the self is never a finished entity, but is continually evolving. The role of the researcher is primarily to discover the realities of the subjects, and how they define and experience their world (Bowers, 1988). From the perspective of symbolic interaction, human behavior is the result of basic social processes. "Individuals acquire a sense of self through interaction with others; and people, likewise, through shared experiences, create meaning that influences their collective behavior" (Powers & Knapp, 1990, p. 62).

These concepts are seen as applicable to the present study. No empirical research appears to have been generated on the topic of the grief therapist as a person, and the paucity of studies in the field of psychosocial aspects of therapist development, have focused on psychotherapists and counsellors in general, rather than specifically on therapists working in areas of grief therapy. Therefore, it was decided that the grounded theory method be used to investigate this topic, due to its ability to generate theory in this much needed area of research, and to avoid applying pre-existing models from general therapists, which may or may not be appropriate to grief therapists. It offers also the possibility of describing the processes taking place in the grief therapist, and has a practical applicability. It is hoped that this study adds to the understanding of grief therapists and how they experience their world.

In summary, it has been asserted that the grounded theory approach is particularly useful in providing "an opportunity to create theory in subject areas that are difficult to access with traditional research methods" (Rennie, Phillips & Quartaro, 1988, p. 140). Grounded theory research dictates methods of data collection and analysis, the generation of research and interview questions, and the relationship between the researcher and the date. It is not limited to a description of data only, but emphasizes a discovery of the process or change that takes place over time (Chenitz & Swanson, 1986). The concept of Basic Psychosocial Process (BPP) in grounded theory research highlights the fact that an interaction occurs between psychological factors occurring within the individual and the individual's social environment (Chenitz & Swanson, 1986). As a core category, the BPP can account for the variations that occur in behavior and perceptions collected from the data, and is generalizable or possibly applicable to other populations as well.

Role of the Researcher

Rather than attempting to remain neutral, detached and objective, the grounded theory researcher intentionally becomes immersed in the world of the research subjects. The researcher attempts to discover what that world is like, and how it is constructed and experience (Chenitz & Swanson, 1986). By taking on this role, he/she is purposefully placing him or herself inside the object worlds of the research subjects. This is done for the purpose of understanding the subject's phenomena in the subject's world and from their perspective.

At the same time, the researcher attempts to maintain one foot in the world of the subjects and one foot outside that world; he/she attempts to view actions from the perspective of the subjects while also standing back and asking questions about what the subjects take for granted. This stance, known as "marginality" facilitates the researcher's ability to view the subject's world from the inside while maintaining the distance necessary to raise analytical questions (Chenitz & Swanson, 1986).

The primary source of data collection in this study was formal, in-depth, semistructured interviews with individuals who had indicated having experience and expertise working as therapists in the area of grief therapy. An interview guide was used in the interview process (see Appendix B). All sessions were audio-recorded and then transcribed into written format for data analysis. Additional sources of data included brief biographical information from the participants, and the investigator's field notes and memos. The data were examined for descriptions, patterns, common themes and relationships, using the constant comparative methods of analysis.

The Sample

It was important to select key informants who had knowledge, relevant information, and experience in the area of grief therapy. Participants in this study were selected by word of mouth by colleagues who either knew these individuals personally, or had worked with them. All were known to have expertise, and interest in working with grieving patients. None of the participants were known personally or intimately by the investigator, although in some cases their acquaintance had been made as a fellow professional in the field of psychology. No restrictions were made in terms of theoretical orientations, or education, although attempts were made to choose individuals from varying backgrounds. Thus, several were in private practice, while some were employed by large institutions. For some, grief therapy constituted the sole focus of their practice, while for others, although grief therapy had at one time been a major focus, it no longer could be said to be their only area of expertise. In total, five therapists were interviewed.

In the initial contact, the sample were contacted by telephone and the focus of the study was explained. Upon the candidates indicating interest to participate, a letter and questions outlining the purpose and focus of the study were sent, in order to allow the participants some time to consider their answers. All participants signed a consent form before the interviews were conducted (see Appendix C). In the end, the investigator selected all interested candidates. The sample consisted of five participants, one male and four females. The age range was between 30 and 50. The educational level varied from graduate school to post doctorate. The theoretical orientations represented included gestalt, art therapy, behavioral, and psychodynamic.

Data Collection

A brief biographical information sheet was filled out (see Appendix A), mainly to provide basic information regarding age, gender, marital status, and level of education. The information remained deliberately brief, as it was expected that the interviews would themselves yield much more detailed information about their personal lives.

The second source of data were written transcriptions obtained from the semistructured interviews, involving the participants and the investigator. This served as the primary source of data. All sessions were audio-recorded. The locations for the interviews varied, with some in offices, and some at the investigator's home. In all cases, attempts were made to have the interviews take place in private surroundings with minimal interruptions.

The interview process consisted of three phases: an introduction to the study, the interaction interview, and the termination of the session. All interviews were completed in one session, lasting on average about two hours.

Within the first phase of the interview process, the study was explained and introduced. The issue of confidentiality of all information was reinforced.

The second phase, the interactive interview, consisted of an informal discussion of the participant's experiences, using the interview guide in most cases a general framework (see Appendix B). The number and sequence of questions varied, but generally addressed the following areas: (1) particular experiences which are highlighted in their careers as grief therapists; (2) personal losses; (3) influential people in their life; and (4) personal qualities they have developed; and (5) how they see themself as a person. As all participants had access to the questions beforehand, some showed evidence of having given some thought to the questions prior to the interview, and began without much direction. In several instances, the interviews began in a more rigid question/answer format, but as the participant became more comfortable, shifted to a more free-flowing exchange. The role of the investigator was to attempt to keep the participant focused on the research question, without inhibiting the natural sense of spontaneity of answers. Throughout the interviews, the investigator attempted to develop rapport and feelings of trust, and displayed support and a nonjudgmental attitude, as well as sincere interest in the participant and in what they were saying. Open-ended, reflective, paraphrasing and clarifying questions were used to gain a greater insight into the participant's personal experiences and perspectives. The investigator found her training as a therapist a valuable asset in conducting the interview.

In the third phase, a short time was spent on reflecting back over the session, and in particular, discussing how the participant felt about the session. In each case, there was a sense of warmth regarding the human contact and personal revelations. Several indicated that the interview had allowed them to reflect on issues that they had not uncovered before, bringing certain feelings to the surface. Some indicated that they found themselves rethinking their lives again, and aware of certain influences and goals for themselves. On the whole, each participant also offered some expression about the feeling of closeness and warmth they felt, both in the human contact and on the focus on personal revelation in this study. This feeling was shared by the investigator, who found herself feeling touched by the intimate revelations, as if a special human encounter had been experienced. Upon the conclusion of the session, there was a feeling of regret that it was indeed over, and a wish that the contact could go on, with the thought that it was a privilege to have spent time with this special person.

The possibility remained to recontact the participants for further elaboration and feedback regarding their transcripts. However, due to the richness of the information gathered initially, this was thought to not be necessary, and no further contact occurred.

Field Notes and Memos

Field notes were documented on each interview following the interview, consisting of the investigator's impressions of the interviews, nonverbal behavior of the participants, and general feelings about the insights which were brought forward.

The investigator continued to maintain memos throughout the study, recording her impressions, personal feelings, and thoughts about the emerging patterns and themes which arose out of the data analysis. These memos were dated and written in diary format. Such documentation helped provide the investigator with an opportunity to reflect upon the research process and to heighten self-awareness about the process, with attempts to monitor possible personal biases. These memos became enhanced during a period of personal crisis for the investigator, upon the death of a close friend, and became a major opportunity to work through feelings of loss personally, as well as relate to the data obtained from the participants.

Data Analysis

The data were analyzed for descriptions, common themes and relationships, using the constant comparative method of grounded theory. Two coding systems were used to help categorize the data and identify relationships. The aim of the analysis was to find an underlying Basic Psychosocial Process, or central category that explains the variation in the data. Data analysis continued to saturation, or until no new categories emerged.

The views about qualitative data analysis points out that the more extensive the training of the researcher, the more integrated and dense the theory will be; experience provides a background from which to interpret what is seen, and serves as a basis for making comparison; the analyst must have confidence in his or her ability to interpret what is seen in the data, and in the end to believe in the findings (Chenitz & Swanson, 1986).

In the constant comparative method of data collection and analysis as advocated by Glaser and Strauss (1967), the data analysis begins with data collection. The major task of the researcher is then to code the data into categories, and then to define, develop, and integrate them. This takes place by asking questions of oneself and about the data, which may arise out of the data, or out of one's experience. Ultimately, through the constant comparative technique, a link is developed between the collected raw data and the emerging theory.

In this study the data was analyzed line by line, using a variety of codes to identify characteristics and processes. These codes were referred to as substantive codes, as they are grounded in the data, and often use the precise words of the participants. Coded data which appeared to form clusters or groups were assigned specific categories.

The next phase was that of concept formation, in which categories which appear to be significance to the participants were identified.

The third step was of concept development. Here the categories were linked together into higher order categories or major processes "core variables" (Glaser & Strauss, 1967). Selective sampling of the literature occurred at this phase to add to the data, which is incorporated within the categories and conceptualization. Concepts were further delineated through testing, expansion, and qualification using the process of theoretical sampling. The process results in saturation of categories. Through the process of concept development (reduction, sampling of the literature and selective sampling), the core variable, which is central to the data, emerged.

Concept modification and integration occurred when the emerging theory was strengthened and integrated. Linkages were made among the categories, and questions about relationships were posed and hypothesis tested. Memo writing was used to document tentative concepts and hypotheses, and were all grounded in the data.

Once the categories had been built and linked, they were pulled together around a central or core category. Diagrams were drawn to arrange the categories in hierarchical order. The data continued to be checked and rechecked. Finally the theory was refined, and laid out in the form of a diagram. The end results of the work was a "grounded theory" that explained the major action in the study. In grounded theory research, categories should be dense with concept and saturated to the point that a range of variation can be accounted for, verified by hypotheses testing, and integrated, and woven together (Chenitz & Swanson, 1986). According to Rennie, Phillips and Quartaro (1988), the resulting theory should meet the following criteria: (1) offer the reader a plausible explanation; (2) be comprehensive of the data presented; (3) be inductively grounded in the data; and (4) be applicable and lead to future hypotheses and investigation.

Reliability and Validity

This study attempted to establish in its collection of data and its analysis, results that are reliable and valid. These concepts, also referred to as "trust worthiness" (Lincoln & Guba, 1985, p. 290), involve the following: (1) establishing confidence in the "truth" of the findings (internal validity); (2) applicability to other contexts (external validity); (3) determining consistency or whether the finding could be repeated if the inquired were replicated (reliability); and (4) establishing neutrality, or the degree to which the findings are the results of or are determined from the participants, and not affected by biases, motivations, interest, and perspectives of the investigator (objectivity).

A theory is considered valid if it represents the truth of the participants' experience. The following will be a discussion of some of the attempts that were made to address making the theory representative of the truth described by the participants. The concepts specifically addressed for establishing credibility are prolonged engagement, persistent observations, triangulation and peer debriefing.

The research setting involving privacy and warmth, and lack of time restrictions, was conducive to the establishment of trust and rapport between the investigator and the participants. This appeared to meet the concept of "prolonged engagement" (Lincoln & Guba, 1985), wherein there is sufficient time to test for misinformation by the investigator, and to build trust. The rapport between participants and the investigator was particularly enhanced, as the investigator was herself a therapist and thus in the same profession as the participants. Furthermore, a record of memos before and after the interviews helped this investigator become aware of my biases and presuppositions. Due to the richness of the data in the initial contact, persistent contact (Lincoln & Guba, 1985) was not deemed necessary. Triangulation was achieved indirectly by the interaction of the investigator with her supervisor who was herself an experienced grief therapist who thus could relate personally to the data. Peer debriefing occurred at an informal level as this investigator used discussions with various therapists in her work setting to review several issues that had arisen from the formal interviews. For example, the topic of self-disclosure with one's patients was discussed with peers who were not directly involved in the study, with attempts to explore some of the issues brought up in the interviews. Furthermore, peer debriefing with fellow therapists provided an opportunity for catharsis for this investigator after an intensive interview. Although formal member checks, wherein the reconstructions by the investigator could be available to the participants for feedback and checking were not administered, participants were offered easy access to this investigator should they wish to discuss issues further. None found this to be necessary.

Threats to internal validity included: (1) focusing only on the subjective experiences of the participants, who often were relying on a description of events that had taken plan at some time in the past; (2) observation of the therapist at work was not made possible, nor was there any detailed analysis of the therapist's competence or effectiveness as a grief therapist; and (3) lack of adherence to changes in the participants as affected by the investigator, such as possibly considering that there may have been some hesitancy on the part of the participant to reveal personal information to a relative stranger.

The concept of external validity or generalizability, also called applicability or fittingness (Lincoln & Guba, 1985), was enhanced by deliberate sampling of individuals from divergent theoretical backgrounds and experience. Attempts were made in the initial selection of the participants to choose individuals who had demonstrated expertise in various aspects of grief therapy. These included choosing participants from private practice, current doctoral students, or researchers, and from various theoretical orientations such as gestalt therapy, art therapy, client-centered and psychodynamic psychotherapy.

Consistency or auditability addresses whether the data can be replicated or understandable to an outside reviewer of the research data. This was achieved by an audit trail which included journal-type notes and memos regarding the process and analysis of the data, as well as memos of the investigator's feelings throughout the different stages of the study. These notes and journal entries were kept and reviewed, and incorporated into the analyses of the categories.

Verification of the results took place through an in-depth interview with an outside grief therapist not directly involved in the study. It was found that the basic psychosocial process identified in this study was in agreement with this therapist's experience.

Delimitations

This study was delimited in a number of ways: (1) the sample size was restricted, and included individuals who were not necessarily currently active in grief therapy, but who had been in the past. Thus, the definition of grief therapist varied from person to person and therapists had different levels of experience; (2) verification involved an interview with one experienced grief therapist; (3) participant observations were not considered as part of the data collection, so that all the information came through reflection; it is possible that concerns about anonymity and self-disclosure may have limited some individuals to saying everything they might on a particular topic; (4) the effects of the investigator's presence may have affected the degree of spontaneous involvement on the part of the participants; and (5) the research question focused on grief therapist's view of themselves, and thus did not consider other aspects such as the patient's perspective of the therapist, of the variation of techniques which may have stemmed from the person. It also did not consider the fact that some people may have had an easier time relaying the extremely personal information than did others, or of speaking about themselves.

Ethical Considerations

In this study the ethical considerations included informed consent, voluntary participation and confidentiality. A proposal for this study, which highlighted these ethical considerations was submitted to the Ethics Review Committee of the Department of Educational Psychology for approval.

The participants were appropriately informed of the general purpose of the study. They were required to sign a written consent from prior to participation and participation was voluntary. They were given the option of not answering specific questions, and were free to withdraw from the study at any time.

Their participation remained confidential throughout, and after the study. The maintain confidentiality, code numbers were used on all data during the data analysis, and references to particular participants were omitted in the final write up in order to protect their identities totally. All audio-recordings and transcriptions were kept confidential. Some information in the final report was censored. Any information which may contribute to their identification, e.g., names and places, was removed.

CHAPTER IV

FINDINGS

An Overview

This discussion of the findings is organized into three separate sections, which culminate into a description of the Basic Psychosocial Process (see Figure 1).

The first section, the "acquiring self" summarizes the salient external influences in the therapist's life, and features references to critical incidents, losses, and relationships with significant others, which affect the therapist's development as a person.

The second section, the "integrating self" focuses on the personal qualities which these therapists have both identified in themselves, and have attempted to develop as part of their personality. A summary of their personal characteristics, philosophies about life and death, and personal reflections about therapy techniques are emphasized. It is asserted that these aspects are an integration of qualities that can be termed the initial components of the "therapist identity," and are features that will be continually developed, and reframed, as the therapist continues to grow and change throughout life.

The final section points to the centrality of the "emerging self," where the themes which grief therapists point to as particularly significant to them as individuals are highlighted. These themes together emphasize the therapist's crucial "use" of themselves in their relationship with their patients. Thus it

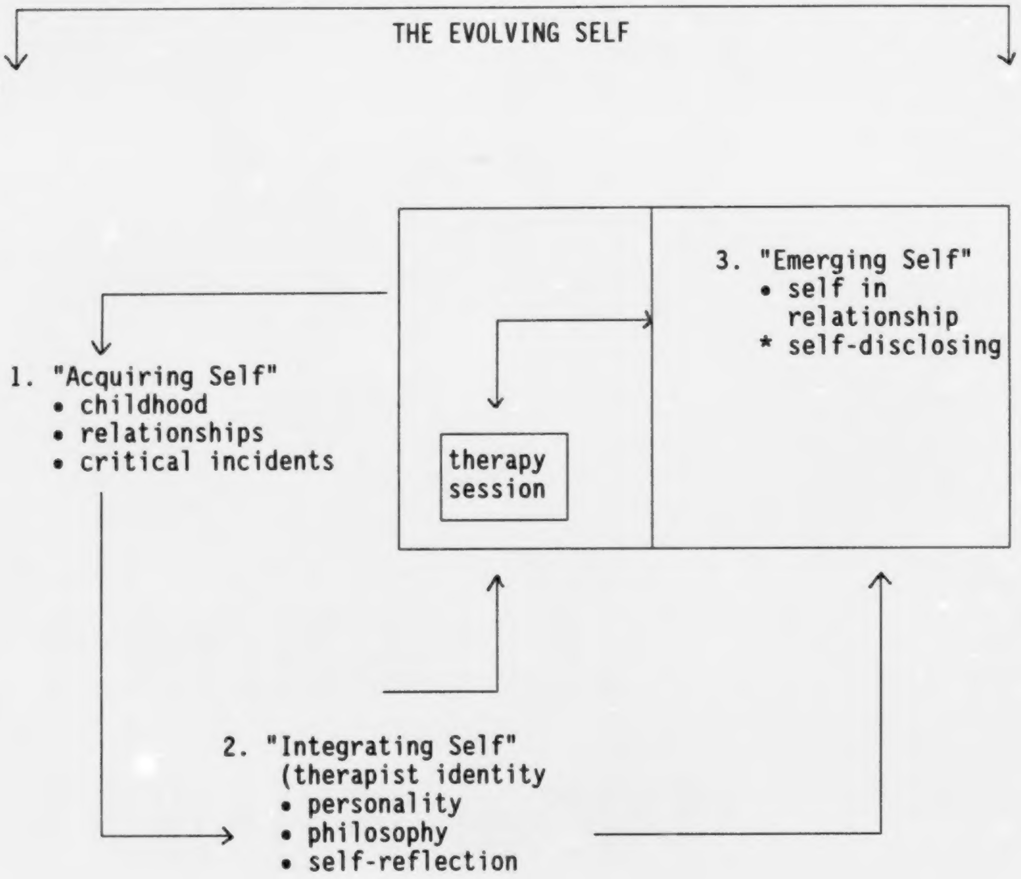
THE EVOLVING SELF
1. "Acquiring Self"
• childhood
• relationships
• critical incidents
therapy session
3. "Emerging Self"
• self in relationship
* self-disclosing
2. "Integrating Self"
(therapist identity
• personality
• philosophy
• self-reflection

Figure 1: Dimensions of "Self" in the Grief Therapist

becomes apparent that the "emerging self" combines a focus on one's self (e.g., self-awareness and self-valuing), with a focus on the relationship and interactions between the therapist and patient, which are experienced in grief therapy as extremely intense and personal. Highlighted in this study is the significance of self-disclosures in the therapy interaction which occur because of the therapist's heightened self-awareness.

This study proposes that the Basic Psychosocial Process which occurs for the grief therapist is thus an evolving sense of self, one that is first "acquired" by various external events in the therapist's life, then "integrated" through introspection, maturity, and various life experiences, and finally "emerging" as a result of relating with the patient in a dynamic exchange. During this exchange, both patient and therapist are "changed" as a result of their interaction: the patient, because of the opportunity for therapy and the presence of the therapist, and the therapist by experiencing an increased sense of self. This is often manifested in a feeling of being more capable and confident to share oneself with another, or to utilizing "self-disclosure." The therapy session offers a milieu where these three dimensions of the therapist's self is displayed, and the entire process can be seen as one of change, insight, and personal growth on the part of the therapist.

"Acquiring Self"

A number of external influences appear to contribute to the therapist's concept of self, termed in this discussion the "acquiring self." Often these experiences stand as major influences which are imposed upon in the individual, stemming from early life and family experiences through various highlights in their careers. The areas which will be highlighted in this discussion are: (1) childhood; (2) critical incidents; and (3) personal relationships.

Childhood

Two major areas are emphasized by these therapists in terms of childhood experiences: there is a tendency for these therapists to have been as children, relatively serious individuals, high achievers academically, and somewhat overly mature for their years. Several pointed out that at an early age there was a propensity for people to confide in them, or simply turn to them for advice. One therapist recalls the relationship she had with her parents as one where she was her mother's "confidante" and her father's "buddy," early on, seeming to develop the role of "a shoulder for them to cry on" and a good listener and adviser. It is also evident that the function was not always reciprocal: therapists did not always receive the same amount of nurturance and attention they seemed to give to others. Another therapist indicates that the philosophy she learned from her parents was "to thine own self be true." One of the highlighted events in her childhood was of attending a funeral and recalling, "I was frightened out of my mind." She would later become, as a therapist, an active proponent of children being involved in funerals and other rituals, because of her own unpleasant childhood experience, as she says:

> I realized children need to be a part of it, but also have loving talk, loving holding, touching, lots of time where adults will not

> be so caught up in their own grief, but will be able to talk with the children about that, and reassure them. Because I think what I needed then was reassurance. I was very frightened of death at the time, for a long time.

It appears that early childhood patterns of being available to people, and interacting with people, helped develop skills for the "budding therapist" which would later be useful in their careers. One therapist summarizes her view as an adult with the following: "I feel comfortable listening to people, hearing out rather than talking."

One of the apparent similarities among the grief therapists involves their maturity and sense of respect toward their relationship with their parents over the years. One therapist describes how before the death of her father, there was no "unfinished business" between herself and her father, and that her training as a therapist helped her prepare for his loss, for "It seemed that I knew that that was going to happen." Another therapist was able to accept her parents' limitations in providing emotional support for her; another took the opportunity to tell her mother how much she loved her, which she had never done before. All the therapists indicated that their parents played a significant part in their personal growth and development, but each one also indicated a distinct sense of autonomy and ability to move on in their own lives, with undue enmeshment in their family of origin.

Critical Incidents

Every grief therapist can point to various highlights in their development as a therapist, both professionally and personally. Many of these critical incidents involve losses whether through death, the ending of a relationship or making a major life change. These individuals seem to use their experiences to various extents: One therapist emphasizes how her position as a "wounded healer" – one who also has suffered personally like the patients she treats – helps her better identify with her patients, as well as provide her with a chance to be seen as a role model as someone who has survived personal tragedy too. Another therapist recounts how her personal life appeared somewhat idealistic and free of complications until the sudden tragic death of her husband, which spurred her on to greater personal accomplishments. A third therapist recounts how one of her critical incidents involved immigrating to a new country whereby she learned to survive hardships which ultimately made her more sensitive to other people's struggles. And a fourth therapist points to the significance of making a major lifestyle change, moving from a life in a religious order to a secular lifestyle, but a decision which helped confirm her personal priorities, extend her influence to others and ultimately be true to herself.

Therapists often indicate how they have found inspiration from their patients and for some these interactions become critical incidents that have a profound effect on the life of the therapist. One therapist, while working in a hospital, recalls the experience of holding an aging grandmother in her arms during the woman's dying hours, and pointing to this incident as the turning point in her career, for her of moving from general nursing into grief therapy. This same individual also describes the impact that the death of her baby daughter had on her life. She found herself working through the stages of mourning: pleading with God, openly expressing anger and ultimately finding that she came in touch with her own "inner child" and sense of self. She indicates that "in her dying, Mom got her life back, literally." Thus, even personal tragedies can lead to crucial opportunities for growth.

A therapist's early experiences as a clinician were often highlighted as particularly significant to the therapist's development. One therapist recalls the impression that was made upon him during his first job at a cancer clinic, where he became aware of the "powerful feelings" that arose in his contacts with dying or grieving patients. Similarly, another therapist recalls the impact her first patients had on her when they developed intense bonds to her as a therapist, and attempted to remain in contact even after she moved. For one therapist, the death of her father helped him experience firsthand the various stages of the grieving process which he could see included such aspects as: anticipation, realization, acceptance, and confrontation, which he would later see exemplified in his own patients. Similarly, the loss of his marriage was seen to compare to "a loss like a death." This therapist explains that through his experience of personal pain, he discovered a new-found sense of autonomy and internal strength, which allowed him to give himself "permission" to be vulnerable and feel. These experiences also helped him recognize the importance of accepting people in their grief, as he too was helped by a friend who stayed with him, tolerated his emotions, resentments, and memories. In the end, he feels that he "grew as a person," seeing himself as a "leader" in his own family.

The effect of a colleague's suicide was highlighted by one therapist as a loss that helped her realize just how one person's life can influence so many others. This tragic event also helped her get in touch with the feelings of responsibility and guilt that are often a part of grief therapy. Many of the therapists were especially honest about their own vulnerabilities, some referring to going through bouts of depression, or even becoming aware of their own defenses, such as hesitating to get too close to people, especially in the work setting where the turnover rate is high and thereby offering a constant "loss" experience.

Death of a loved one was often highlighted as a significant developmental marker. One of the therapists speaking about the death of his father, points out that he was forced to face "the upset . . . real worry . . . and fear" that first signalled the anticipatory grief. He became aware that the process of his father's dying could too become a time of growth for him as his son, as he gradually came to a feeling of acceptance and ability to continue "talking about him and about that and having him talk about his suffering." Unlike other family members who continued in a state of denial, he kept himself informed about his father's deteriorating condition and was directly involved with the medical staff until the end. Anniversary times were also seen as difficult reminders of one's losses, some therapists pointing to special holidays such as Christmas as times when "that's when it really hits" and possibly an awareness that the grief is never fully over.

Another therapist who describes her feelings about the loss of her mother says that her personal approach is in attempting to be present to the person dying, with the belief that "the person does not need to die alone." She was able to incorporate times of talking, singing, praying, bringing the family together and using both her presence and her spiritual beliefs to work together in order to say good-bye to a loved one. Throughout her description of the event, there was an attitude of caring and acceptance that death indeed was a natural and human experience.

Educational experiences were often highlighted as significant turning points in a therapist's life. For one therapist, her opportunity to move into graduate school was instigated by the sudden death of her husband. She initially appeared to use her studies at university as a means of maintaining the structure and purpose in life that she need at that time, and perhaps found the hectic pace of her studies a means of defending against her intense grief. However, her loss also made her feel "different" from the people around her, and as a young widow, she describes how she felt she had "skipped a generation" and joined that of her mother's. Furthermore, she clearly experienced the reversal of parent/child roles as an adult, when she was forced as a daughter to provide comfort and support to her grieving and widowed mother.

Relationships

Each therapist emphasizes the significance of various relationships which have influenced them both professionally and personally. These include their families, spouses, close friends, mentors and patients. For some therapists, their focus as professionals is found clearly in their personal relationships. As one therapist states, "being a therapist gives you 'relationship skill'." Often the insights that are gained from their patients are incorporated into how they conduct grief therapy as well as into their own self-concept.

One of the most significant relationships and significant losses that one therapist points to is the loss of his first marriage, which to him parallels a "real grief process." What is important about this description of his feelings and behavior at that time is the awareness that he would indeed grow from his experience: "Deciding I had to live by myself, for myself, before I could be in a relationship for myself." He describes with honesty how he found himself return to holiday spots and "yearning and searching for her." It is evident that what he found healing was the self-reflection: "I gave myself permission to do those things," and realizing his own inner resources, "discovering myself and learning to live better with myself."

One therapist who made a major lifestyle change did so largely through the support of the individual who eventually became her husband. She describes in the following the influence that this person had on her life as she left the convent for a secular life: "The love of my now husband, a very special,

special person, who shared my values and my dreams and my hopes. And who has been a major support in my life . . . I lucked out in finding someone who shares my values, my dreams." Another therapist refers to her husband as a "wonderful man" who challenged her rule about not dating a patient when she worked as a nurse. Clearly, spouses have a particularly powerful influence on the life of the therapist, and each therapist makes reference to the profound inspiration and support they receive from their spouse both personally and professionally.

For many, the insights that arise in the therapy situation are incorporated into the therapist's personal life. As one therapist admits: she and her husband are always open to trying new ways to communicate based on the emphasis she makes of that in the therapy she does. Another therapist points out that after his second marriage he found a new-found assertiveness and ability to take charge of his life, which ultimately reflects the growth he had made after a major significant loss he experienced. Intimate relationships were not only valued for what they provided for the therapist personally, but were also seen to contribute to the therapist's ability to empathize with their patients, and to more genuinely understand the significance of major losses in relationships for the patients.

Each therapist's family was mentioned as having a powerful effect on the therapist's life. Several therapists emphasized their close-knit families which were supportive and nurturing to them all through their lives. Even in the case of one therapist who, on the contrary, came from a "dysfunctional" home life which involved physical and sexual abuse, she indicated that at least she had been able to come to terms with her relationships with her family as she grew up. Another therapist came to see the limitations of her family in providing the support she needed, and she found herself turning to other people more than to her family to get what she needed. One therapist speaks about the great influence of her poor upbringing as "we couldn't be better than thou; we were very simply people." However, through her family she developed a sense of dignity as she describes how her family warmly welcomed strangers and helped people in times of need. She indicates that it was from the example of her parents, who welcomed neighbouring Indian families into their home, that she grew to appreciate learning from people of all cultures. It is evident that her respect for people and personal values are rooted in her family and religion where "we are all one people, all one . . . each human person is created in the image of God and we are all making up a people and we're all of worth and there's not one that is greater than another." The values and the experiences that derive from families are carried with the therapists both into their personal life and their character but also in their approach to and interaction with their patients.

All therapists describe the significance of friendships in their lives. One therapist describes how the support of a friend who stood by him when he was grieving the loss of his father, not only helped him through his grief, but created a deep bond between that person and himself. He emphasizes the importance of having someone there to simply listen: "just being with me" and allowing him to be "vulnerable and exposed." Another aspect in the friendship was the way it gave the therapist hope and the ability to reflect on possibilities for the future. In turn, the therapist uses the same attitude in relation to their patients. Friendships help the therapist not only become better oriented to understanding and listening deeply to others, but helps them develop personal confidence, trust in themselves, and to relate more genuinely to others. Friendships were also described as evolving. Most therapists spoke of constant friendships which endured, but also about short relationships with people, or a change in their social groups at different phases of life. It was also clear that when families were not available, the therapist found adequate resources in friends.

Another therapist describes the support she received from a good friend who helped her in a practical way. When she was suffering from insomnia shortly after the death of her husband, a doctor unwittingly suggested, "have you thought of getting married again?" Instead, a friend offered to accompany her on early morning walks and thus helped alleviate her insomnia. It appeared that the solution worked on two levels: the practical and physical reality of exercise, and also just as importantly the support and reassurance that involved accompanying her friend and personally sacrificing her time in order to be helpful. In the end, the therapist finds "That was wonderful. That's friendship."

On therapist describes the inspiration she received from her dying uncle, who despite his pain and terminal illness continued to entertain children: his generosity moved her, in that he could be so giving to others, while obviously suffering himself:

> He had always been a very carefree person, full of life. Loved to gamble. Maybe one of those people that your patients would say, don't emulate him, don't follow, him. And yet he was so ill. Even two weeks before he died, he said, "I'm going to see the children. You should see the children. One of them can't even say the word. She said "I got 'kemia, you know." And he says, now I can go there, and I can do slight of hand stuff (like he can take his thumb off and he does jokes with the kids). And I thought what a man. Here he is teaching me to die. He was saying, I'm ill and his stomach distended and his skin darkened with the cancer. Even that close to death, he was still reaching out to others. Giving his gift away, which was his fun-loving . . . His generosity, of saying, "I'm not going to be bitter and angry and say that I hate everyone, and God's not good and life is not good. But in and through my pain I can reach others."

Patients too become examples of significant relationships for therapists. One therapist recalls the first group she did alone and her feelings of inadequacy, partly as she was picking up on the trauma of her patients, but also her awareness of getting in touch with her own feelings. She found herself reflecting on how much she herself was struggling with losses of relationships in her own life: leaving her friends in eastern Canada, having to accept her husband's problems with tendonitis which caused him to have to terminate his career as a musician and lose his business, and the general feeling of loss in relation to her family living a great distance from her. She recalls the feelings of guilt and anger that she experienced in her work, and while aware that these feelings were also projections on to her by her patients, there was a definite sense of helplessness – "that there was nothing you can do about that and hitting my own defense." Her description indicates the strong feelings that can arise in the therapy session for the therapist as they relate to the patient but which can be acknowledged as useful and important. This therapist indicates that she is both affected by her patients personally as well as aware that the feelings that arise in her also partly originate in her patients, can be used as a means of increasing her understanding of her patient's own internal world.

Difficult relationships also offer therapists an opportunity for personal growth and self-awareness. One therapist describes the sense of isolation she felt when after the death of her husband, she became designated a widow, a category of women she had previously always only associated to her mother's generation and not her own. Similarly, she felt distant from her former friends and classmates of her deceased husband, describing how she often felt like a "fifth wheel" in their group, since she was no longer part of a couple. She also experienced the loneliness and desperation that can possibly lead people to make inappropriate choices in relationships at times of vulnerability such as in grief. She learned to turn circumstances around for herself where relationships become not opportunities to be hurt, but from which she can learn, and came to experience her own strength as a person. Later, after a brief time of dating, she was able to resist the easy temptation of falling quickly into a new relationship soon after the death of her husband, and affirms with a greater sense of personal awareness: "I just shudder when I think of it had I married him" [a date].

Each therapist refers to the influence of various mentors in their life. Some were people who helped them personally by functioning as role models which in turn affected their relationships with their patients. Some seem to have chosen high-profile persons, known for their expertise in the area of grief therapy, who inspired them personally as well as in their career endeavours. Others point specifically to their teachers or to colleagues who inspired them and made a difference in their life. The role of the mentor appears to be a combination of someone who provides personal support, challenging the individual to achieve their best, and most of all helps the individual feel not only respect, but special. This is evident in the statement that one therapist makes about how her mentor, Elizabeth Kubler-Ross, who challenged her with the words: "My dear, you have a gift. Use it."

It is evident that the external relationships contribute dramatically to the therapist acquiring a sense of self, both personally and professionally. Childhood experiences, critical incidents such as significant losses, and influential relationships offer the therapist opportunities to identify, develop and maintain some of the qualities which will be significant in their future. The "acquiring self" is seen as a step in the attainment of confidence and character that will later be a valuable asset in the therapist's future. Critical incidents, childhood experiences and relationships offer experiences that have often been imposed upon the individual, and often initially experienced as traumatic or extremely challenging, but which also often turn to being an opportunity of growth and personal enrichment for the individual. Grief therapists seem to have a capacity of making use of their personal experiences, using them to both understand and relate better to their patients, and to further enrich their own life and self-awareness. The "acquiring self" is thus one which is open to experiences and external influences, and which values the learning that can arise out of living and relating to others.

"Integrating Self"

Developing a Therapist Identity

Connected closely with the therapist's acquired identity as a therapist and also as a person are the internal influences, namely such aspects as personality characteristics, personal philosophies, and personal abilities. The beginnings of a "therapist identity" are seen clearly, as the identity becomes even more clearly integrated into the person's sense of self. The integrating self is an *active process of reflecting on the self*, comparing oneself to the patients, and identifying and connecting to the patient. Much of the basis of the therapeutic techniques which a therapist will incorporate, will stem from the integrated sense of self and identity as a therapist.

Research on therapist characteristics have identified numerous useful and essential qualities that may typify "integration." The qualities highlighted from this study indicate that therapists make use of intuitive qualities and trust in their own instincts. One therapist, for instance, was able to appreciate a patient's growth, in the changes he perceived as related to her:

> The other day I was seeing a client who was extremely angry and going on with her anger and as she did that I started to smile. I mean, I was hearing her anger and made that clear, but I was smiling about how it was so amazing in seeing her be so incredibly solid in where she stood on an issue when she so repeatedly said she did not take stands on issues. That was what came out of that sharing, what I was seeing and realizing, and that part of her was perhaps more rock solid than she thought.

This therapist also points out that he has become keenly aware of his personal limits, and indicates that through his maturity as a therapist he developed more realistic expectations of himself. He points out, "I can't be everything to everyone, and I probably have more realism in my goals and more realism in my personal life in what I can accomplish and what I cannot."

Another therapist highlights her value in being an independent thinker, with great self-respect. She states, "I value myself. I think I'm smart. I think I'm fair." Her self-confidence and high self-esteem are clearly evident. She also indicates that she tries to have the courage to say how she feels and how she see things, but also is able to see that in her work as a therapist, this may clearly come easier to the therapist than to the patient. Therapists emphasize their feelings of competence about their abilities, but these are often tempered by humbleness. They admit mistakes, but also point out that they learn from their mistakes, and are open to changes. They value directness, as one therapist states, "I owe them the trust about what I see, and I think I can always couch it in words so I'm not hurting them." There is a pervasive sense of respect, not only for the patient, but for oneself.

Some therapists balance a tendency to be idealistic and pragmatic. While many are extremely active in their attempts to offer their services to others and may be involved in various therapy endeavours such as marital and family therapy along with individual grief therapy, they also recognize the necessity of focusing their energy. Thus one therapist states, "I realized the need to also take care of myself, and fill my own self. And I often do that by reflection and meditation and I will just be still and just say, I am unable to at this time." Self-reflection offers an opportunity to replenish oneself; grief therapists value times of relaxation where they can take care of their own emotional needs too.

Pondering the Meaning of Grief and Loss

Grief therapists have thought about death. The participants in this study shared a number of ideas about their meaning of death, which reflects their values. One therapist indicates her attitude of courage as she faces the idea of death for herself, saying:

> I don't fear it now. We're all dying from the time we are born. It makes us add life to years and not just years to life. We need to reach out to others and to love them, and to do what we can to build a better world. Take care of our universe. It's also so interconnected. And then you get it back, paradoxically, in terms of your own good feeling and well-being and of wholeness.

Therapists also tend to be particularly sensitive to the personal quality of grief: one person's experience is not necessarily like another's, as indicated in the following:

> It doesn't matter if everyone on the block has had what you had, it doesn't matter. It's personal. Grieving is there to do work. It's there for a purpose. It's healthy. And if I do anything that will short-circuit that or try to cut it off or cut off some of the phases of it, whether it be in anger or bitterness or sadness, then I'll be cutting into that and destroying possibilities for growth.

It is clear that the grief therapist is very attuned to the needs of her patients. The variety of loss issues that may apply to an individual may be numerous: death, loss of relationships, or loss of self-esteem may all occur at once. The therapist is thus often required to take an eclectic position in the interpretation and integration of loss experiences as part of life. The emphasis is on the need for patience and strong sensitivity to what is perceived as essential for the patient in order to be more aware of pathological patterns such as self-blame, guilt, idealization of the loved one, or an inability to enjoy life. Thus, while the goal of therapy is seen as growth for the patient, the results of the therapist/ patient encounter may simultaneously lead to growth for the therapist.

"Grief Never Totally Ends"

One therapist points out, "I guess that's one of the things I find about grief therapy, that it never ends." It seems that society often causes people to feel pressured to "resolve" grief issues, with the underlying assumption that the end point of therapy is when the individual no longer grieves openly. However, for the therapists interviewed, especially for those who had experienced traumatic personal losses (i.e., the death of a child or a spouse), the emphasis was on how the loss was never totally over or forgotten.

For one therapist who lost her husband in a tragic accident, she recognizes that her husband's death is still an ongoing issue in her life. She also indicates an awareness about other people's annoyance with her that her grief still resurfaces. She personally also indicates a sense of survivor guilt. It is clearly evidence in her interview that getting in touch with this sense of loss causes her to quickly focus on other people, even in the process of the interview itself as she quickly goes on to state:

> But now when I think about it, I think about my own losses, my children's loss . . . and about the loss of a potential that my husband had in that he died before his time . . . When I talk about that incident, I still get very upset.

It is apparent as well that she feels pressured to present her grief as somehow resolved and "worked through" because of her professional position as a psychologist. But the conclusion that can be made is: it is important to acknowledge that there is still unfinished business and that "maybe that is something I will never completely work through." It is also possible that in partly hanging on to the "unfinished business" she subsequently avoids the sadness and emptiness within herself, as well as attempts to hold on to the memory of her loved one.

Therapists are often very aware of how their own grief issues have influenced their personal life. One therapist points out that just as her own marriage, for instance, had been positively influenced by the fact that she has worked in the area of marital therapy so have her grief experiences played an integral part in her life, for through that, she says, "I know what people are talking about." She admits that "It's a major bereavement that really turned my life upside down . . . when you lose a spouse, you really lose a way of life. The losses affect so many areas." Part of the process appears to involve utilizing the random experiences that are part of life and letting them touch and influence one's life, with the ultimate goal of being able to move past them. All the therapists clearly indicate that their painful losses have actually offered them opportunities to move to greater awareness and insight about people generally. It has also profoundly affected their clinical skills, for as one therapist states, "That sort of makes me a better therapist because I realize the far-reaching implications."

"Making Sense Out of Senseless Events"

Perhaps because of the nature of the subject, grief, and it's connotations with death and with the individual search for meaning, it is natural for many of the therapists to make some reference to their spiritual beliefs. One therapist raises a recurring issue: experiencing one's own losses causes one to examine one's belief system, question God, and also question oneself. One of the commonalities among grief therapists about this subject is now personally each one approaches their beliefs. There is no attempt, ever, to give ultimate answers, to be dogmatic, or even particularly to try to convince others. In fact, on the contrary, grief therapists show remarkable capacity to be open to various ideas, and indicate an ability and acceptance of others about honoring people's rights to maintain their own belief systems. Each therapist shows much respect for both their own and other's beliefs.

Several refer to "spiritual" experiences, but give no indication of promoting a particular formal religion. Some refer to it as "a means to help one make sense out of senseless events." One therapist points out her faith "is not airtight. It comes and goes." However, at a time of personal crisis, such as when her husband suddenly died, she indicates that she found a lot of strength in the fact that, "I really believed that his spirit was sort of around me. That was helpful." Part of her progress, however, was as she indicates, coming into a sense of strength from within herself. She uses her personal spiritual journey as a means of better empathizing with patients who too have spiritual issues, as evident when she states, "I'm not so sure myself, but when they are sure, it makes sense to me." Another therapist emphasizes that the concept of God for her is one of an internal life force, thereby balancing a strong personal conviction of a higher power, with a definite sense of personal responsibility for one's own life.

Some therapists approach grief therapy as an important opportunity to find meaning in losses, or to look at loss as an opportunity for personal growth. Their discussions also often do turn to how spirituality has influenced them personally. For example, one therapist points out that after the tragic loss of their baby, her major question was, "not who is God, but rather, who the hell am I?" The sequence of her thoughts here indicate that the focus never remains on the loss event itself, for that may inhibit movement forward, but rather on looking at oneself and seeing what can be learned from the experience. For this therapist, a tragic event such as the death of her baby actually opened up to her an opportunity for greater self-analysis and introspection and thereby an opportunity of growth in her sense of self. She emphasizes her own belief in making meaning out of "mystical" experiences, as evident in her description of her experience in the following:

> I came home one night. You know how it is when you're really wired from working and running around all night. It's really crazy, and I just laid there in bed. You know how it is when you just blank out, you just have to think. And my eyes were open. And I saw this face. She was about this far from me. I was just looking into the semi-darkness and I was thinking, what incredible eyes. And my other daughter has the same incredible eyes. And it just didn't phase me that I saw these eyes and just the top of here head. And I didn't recognize her, I wasn't thinking. And then the rest of her face kind of came in and looked at her and I thought, "My God, this is Lindsay," so I said inside my head, I said, "Lindsay, is that you?" And she said, "Yes Mommy." And she had a respirator, and when the rest of her face came into view I could see the distortion of one of her nostrils, and it was kind of like I needed that to recognize who she was, and she had the widow's peak she had when she was alive. Awesome. And I reached up to touch her, and she said, "Don't touch me Mommy, otherwise I can't stay." So I just put my hands down, soaking this in. There was just no fear. There was just this incredible love. So I said to her, "How are you?" And she just looked at me as if she just loved every single cell of my being. I can't describe it. Totally open, totally exposed to her and this awesome love. In fact I even thought, that's how God loves. It was just awesome. And then I said, "How are you and what are you doing?" And there was just this incredible feeling of love. And I said, "Can you say anything?" And she

> said, "I can't Mommy, I'm a baby." I reached out to touch her and she was gone.

Each therapist did not offer as dramatic a "spiritual" or dream-like experience as described above, but it was apparent that the various approaches and philosophies that individual therapists adhered to were very much based on personal choices, and that their experiences and approaches to their work adapted to their various philosophical choices. Thus, when this therapist asserts "I trust that everything happens for a reason," she interprets the events of her baby's death as a message about being able to let go of her feelings of guilt. She focuses on being able to "forgive the mother in me for giving birth to a child who could not sustain life." As she applies this concept of forgiveness to herself, it helps her gain self-awareness and also to better understand the experience of others who can become equally burdened with guilt.

Each therapist indicates a strong natural propensity to be introspective; many are people who might be considered "deep thinkers" and who are comfortable contemplating existential issues such as the meaning of life and death. However, there are also themes that seem to resonate for each individual therapist personally. One therapist in particular is characteristically concerned about "serving others" and focuses on a sense of community and the need for people to support one another in times of grief. For her, it is important that people approach grief therapy as a shared experience.

Grief therapists emphasize the fact that grief issues are universal, which helps explain how the therapist's work may easily extend outside of the domains of the clinical setting. Most grief therapists have a strong social conscience. One therapist extends her work with loss and grief into providing therapy as a preventative measure, by focusing on the community and marital therapy or by proper marriage preparation. Another therapist is very active in research and publishing, as well as in lecturing and holding workshops on grief and loss. Some contribute their time to Bereavement Societies and other community services. There is generally an attitude of concern for society and a desire to do one's part in helping others, and in the end, getting a great deal of personal satisfaction from their work and their giving. As one therapist states, "I gain more than I give." All therapists also seem to agree that being a grief therapist puts them in the "special position" of exploring issues that are complex and emotionally laden with questions, regrets, wishes, guilt and changes. One therapist maintains, "grief therapy is exciting in a perverse kind of way."

Thus some therapists approach loss as a time not just of suffering, but as one of possibility and potential, to "reintegrate to a much higher level." Grief is regarded not merely as a hurdle to be surpassed, but as an opportunity to grow in self-awareness and personal strength. Therapists do not appear to indicate a fear of death as such. The passage of time is valued as if it were to "add life to our years, not just years to our life." Grieving is also regarded as a healthy and natural response to loss, and that is essentially about responding to a change in the relationship with people.

"You Can Only Take a Patient As Far As You Have Gone"

Each of the grief therapists interviewed indicated much respect for their profession. One even states that being a therapist is "a wonderful opportunity" and values the close connection that it offers her with people. She also indicates that the work has had "a tremendous impact on my life." Her awareness of her own growth as a person is evident as she points out that because of her experiences, she is a "different person than the one who first lost her husband." She also realizes the value of constantly undergoing a "self-analysis" as she respects the patient's position, for "when the shoe is on the other foot it's hard to see yourself as vulnerable."

One of the most significant recurring themes found in each of the interviews involve the emphasis on therapists being aware of their own issues and being honest with themselves. This applies to various different aspects: being able to apply the issues that arise in therapy to oneself; identifying with the patients and attempting to be empathic as one sees the parallels of the patient's experience to one's own; being highly conscious of the danger of one's unresolved issues interfering with helping the patient. Thus, many of the therapists admitted to seeking therapy for themselves, not particularly around unresolved grief issues alone, but to help themselves become stronger personally in order to be able to better help others. The importance of being able to separate their own issues from those of the patient is indicated as particularly important in the realm of grief therapy as it is a highly emotionally charged and sensitive area for most people to discuss. One therapist points out that, "you can only take your patient as far as you have gone in your own healing." Thus, therapists also recognize their own limitations. It is very likely that a therapist may not have experienced the exact circumstances that the patient has experienced, and so being aware and honest with oneself and aware of one's limitations is in the best interest of the patient.

Therapists generally take an attitude of unscrupulous honesty about themselves. One therapist makes reference to "working through my own unfinished business" and "daring to face the dark side of me, of who I am," which implies that if a therapist cannot be honest with themselves, they cannot expect their patients to be totally self-aware. Another therapist implies that she tries to not let her own issues get in the way of her patients, "not . . . playing those out instead of the client's issues." One therapist emphasizes the importance of looking at oneself, believing that only then can one see the "wholeness and a right relationship with others, and with God."

Given the importance each of the therapists emphasize regarding examining one's own issues, each of the therapists use various means to attain their own self-awareness. Some take part in such aspects as art therapy, discussing issues and feelings with friends, and a constant attitude of self-scrutiny or self-analysis about one's own vulnerabilities and limitations. Many regard their work as a "continuous process" of dealing with issues of "self-love, trust in themselves, and confidence." Furthermore, therapy with the patient is also seen as an opportunity for the therapist to gain insights about themselves.

One therapist points out, "I did a lot of soul-searching." It is in the fact that he could allow himself to feel his losses, share his feelings with others and work through the events which help him come to his own self-awareness, that he can conclude, "It's from those experiences myself that I can be very accepting of what people are saying and comfortable to sit there and listen . . . and not have to feel a certain thing." He regards his own personal losses (losing a father, and a marriage) as helping him be better able to understand grief feelings in others, and thereby be better able to help them.

Formal individual therapy seems to play a part in the lives of most of the therapists. Therapists seem to seek out therapy as a means of arriving at a better self-understanding, both for personal satisfaction as well as to help better improve their effectiveness in helping their patients. One therapist describes the highlight of her therapy consisted of working with a high profile world-renowned therapist who helped her explore her childhood, and get in touch with the anger and hurt of her past so as to "let go." Another patient describes how her own therapy with a Jungian analyst generally influenced her ability to fully empathize with her patients, "When you've sat in the other chair, you realize how difficult it is to come in and talk about these things." In turn, she indicates that she tries to emulate her own therapist's attitude of caring in the way she works with her own patients when she says, "I hear myself saying things that he would say."

She also makes the point that some of the most memorable experiences as a therapist are the ones that derive from her earlier work, for as a beginning therapist she had a greater investment, and it was from those early mistakes that she learned the most. In her interview, she displays the capacity to be both critical and sensitive toward herself, admitting, for instance, her tendency to be "insular" so as to protect herself from being hurt by the people who come and go in her life, both professionally and personally.

It is clear that therapists in need of therapy are in a vulnerable position especially when they are expected to be leaders in a mental health profession. One therapist emphasizes this point clearly as she describes trying to look for help for herself in her community, and ending up being asked to lead a group and help others with the very issues of loss for which she was seeking help personally. Thus, the "patient" sometimes ends up being forced to stay in the role of therapist, despite their personal needs, and perhaps loses in that an opportunity to fully let themselves work through their vulnerabilities. The one in need in fact becomes the one forced to give to others first.

The actual process of performing grief therapy is also acknowledged as especially draining to the therapist and requires an enormous amount of strength on their part. Grief therapy is often described as "hard work . . . . Your resources are depleted. You're tired. You have no life enhancement energy because you've used it all up by crying and weeping and regretting, or being sorry, or being bitter or angry." Similarly, successful therapists recognize the importance of taking time out for themselves to gather their own strength.

Therapists emphasize the necessity for themselves personally to get on with their lives after the experience of loss. This in itself may be a defensive aspect, but also speaks to their own perhaps heightened self-consciousness in appearing capable and in control. For instance, the experience the following therapist describes indicates the sense of urgency with which she continued with the routines in her life after the sudden death of her spouse, with an attitude that, "life goes on . . . the world doesn't stop so you can focus on bereavement. Life does go on. We have to deal with everyday things as well as what happened." Unlike the experience of many of the patients that come for treatment, therapists do not allow themselves to remain in a helpless state, but appear to quickly start giving back to others. It is perhaps somewhat unfortunate that the demands of their work and position as well as possible defenses against their own feelings of vulnerability do not allow them the opportunity to simply be "patients".

Each of the therapists make some reference to how their work as therapists has helped them live more for the moment, and not procrastinate because "Life's too short." It appears that partly because of the losses they experienced, and what they learn about life from the people they work with, helps them value the immediacy of life and offers a greater appreciation for the life that is available now. Unlike other areas of therapy where one may work easily with certain denial, the reality of one's own mortality is inescapable in grief therapy: grief therapists must always be able to confront their feelings about their own death.

"I Don't Need to Have All the Answers"

The question of the therapist's competence and their possible self-doubt was often discussed, and a wide range of feelings expressed. One therapist points out, "Sometimes I feel good. Sometimes I feel incompetent and inadequate." All the therapists highlight the importance of their education; some indicate that they somehow "ended up" working in the field of grief therapy, but that this was often influenced by a number of life events as well as general interest in the field, natural abilities, and competence.

The issues of introspection and self-questioning do appear to be a major focus for therapists, and as one therapist states: those who question themselves more, and who are perhaps a little less confident of their abilities are often more apt to be better therapists than those who are always very sure about themselves. Most therapists seem to indicate a tendency to balance their attitude about confidence and competence and of some self-doubt and humbleness. The therapists indicate that they have a confidence in themselves and a sense of security that they are not afraid to say, as one therapist points out, "Sometime's with clients I say I really don't know. We could try this or we could try that, but I'm not sure. And people really seem to trust that. I don't think I need to have all the answers." Another therapist indicates having a similar attitude, and tries to find out if she is unsure about how to help someone. Her confidence in her abilities is clearly evident as she states, "if I am wrong I can always make up for the mistakes."

All therapists disclose readily what they considered to be some of their mistakes in their work. One therapist described a shortcoming she felt in herself when she omitted asking a suicidal patient if he did in fact have a plan or intent to take his life, only to later learn that he had in fact killed himself. This therapist expresses a sense of guilt and deep regret about having overlooked asking this question. More generally, she recognizes that one of her own personal shortcomings is in how others may misinterpret her, "Sometimes I come across as sometimes not genuine," and has been accused of being "to theatrical." She can admire in her colleagues the predominance of being "genuine and real" without phoniness and pretension.

The therapists' self-awareness also affects how they view themselves as professionals. For some there is some conflict in their achievement of the title of "Dr." One therapist points out that she sometimes feels like a "imposter," partly fighting the stigma of professionals having all the answers, and yet on the other hand she feels very deserving of the title and wants the respect that it implies. She sees herself as a "first-generation" professional and has been tempted at times to assume, like her parents, that professionals are people who must be wiser than the general public. However, she concludes:

> I find that they don't have any more answers than anyone else. What we are is human beings, and we go through life like every-

> one else. And we learn things. But no one has a handle on truth. So my clients trust is as real for them as my truth is to me.

There is then some desire and attempt to humanize the position as therapist.

Each of the therapists, while being honest about their weaknesses and mistakes, were also very open about their strengths and show a confident self-assurance. One therapist sees that her strengths lie in "something about me that is trustworthy." She commends herself for keeping abreast of current issues and trying also to do "what is most appropriate for my clients." She also tries to look at her own issues, "to see what is going on for me, either in the session, or generally, what might be clouding the issues of how I see things, a lot of introspection." As she analyzes herself she sees she generally has good relationships with people but feels she is better at short-term relationships than long-term ones. She sees her personality as "warm, outgoing, comfortable with being self-disclosing," a sense that because of her experience in life what she feels is then not unique only to her. She realizes, "any sort of insecurities that I have, other people have them too" and she can admit when she is not always so sure of herself, as evident in the following:

> I'm comfortable in saying that I feel a lot of times inadequate at times as a therapist because I know very well that most therapists do feel inadequate. And those who don't maybe this is 'cause maybe those who don't should look from time to time at themselves because they may not be looking hard enough. I don't think you can have all the answers. Although maybe that's my issues. Because I, at times, feel inadequate, I want everyone else to.

On the other hand, she also recognizes that she is "fairly confident about who I am." Further, she has come to recognize that "human beings are essentially the same," an attitude which enhances her ability to relate to her patients.

Working Through the Pain: Therapy Techniques

As the individual comes to integrate more clearly their sense of self as a therapist, the therapy session can be seen as offering the therapist further opportunity to utilize, solidify, and reaffirm many of the aspects of their sense of self. The therapy session offers the therapist an opportunity to grow and change in the interaction provided with their patient, so that a new sense of self emerges. The following will be a discussion of some of the various techniques that the grief therapists shared about how they do their work, and ultimately how they "use" themselves therapeutically. The result of these important interactions will manifest in a newly realized "emerging self" which stems from their interactions with the patient in the therapy session. Ultimately, these interactions may be experienced on two different levels: an aspect of the "integrating self" which involves skilfully utilizing various therapy techniques. Interactions with patients in the therapy sessions will also be experienced as part of the emerging self, or of a higher level of personal interrelatedness, which will be explained later.

It is apparent in discussions with these therapists that the techniques each therapist utilize are ones which have some meaning to the therapist personally, being either reflective of their theoretical orientation and personal choices, or of some personal experience. There is no evidence in this study that one particular therapeutic technique is the most effective in helping the grieving patient. It is clear, however, that the therapists work in ways that are comfortable for them and which suit their own personalities. There is also some attempt to taylor the technique to the patient. One therapist may use artwork as a way of uncovering the unconscious; another may suggest a variety of activities such as journal writing, rituals, or gestalt exercises as a means of helping the individual get in touch with her emotions while with another therapist the focus may be on listening and allowing the patient to simply talk or on interpreting unconscious defenses.

For example, one therapist emphasizes how she uses nature symbols in her interpretations and communication of concepts. Thus she explains the idea of growth by making parallels to nature: the planting of a garden or seeds in their dormant phase before growth, are compared to a grieving person who may also have phases of "dormancy" before they can move in into growth from their grief experience.

> To me, nature is full of these symbols. The seasons themselves. There has to be a fall and a winter before our springtime. And I think we're part of nature. I use a lot of symbols. And I guess being a farm gal, the grain of wheat that has to die before it can bear new life . . . . I often invite people to do is to grow something. To get a little bulb and to grow it. Or to have a little patch of something. For you see the rotting of the seed, that pea has to rot before the wonderful fresh peas will come. I think that's one thing I'd like as a therapist to do a lot more. That sometimes we're too talk oriented. Therapy is supposed to be the answer, but symbols speak much more.

Another therapist uses her personal interest and skill with drawing as a means of helping her patients get in touch with unconscious issues that may be difficult to formulate verbally but which are powerfully communicated through their drawings, as evident in this example: "People will draw an ariel view of the situation. They are just looking down on it. You can try to get them grounded, but if they won't ground, you leave them alone. They're not ready to do it. They'll splinter into a million pieces. They're saying they're not ready in the picture." And what is shown to be useful to her patients, she applies to her own life. Her own therapy involves drawings as well, as evident in this interaction with her therapist, Elizabeth Kubler-Ross:

> I drew on little picture. I felt no energy. It was extremely positive. I drew a little black house in the past quadrant. Black is grief and red is anger in her language. That's very simple. And I drew little red flowers all round the house. And Elizabeth said, "My dear, those are not flowers, those are stop signs." And she was right. And then I had to work at what was going on in the dynamics of the family. I worked through all the symbols. The house is the family. And she was absolutely right. There were all those stop signs. Don't go in this house because you are going to get hurt.

Because of the fact that there are no set interpretations or particular techniques of doing grief therapy, many therapists work rather independently with their own techniques, doing what is natural for them individually. One therapist, for instance, states she sees herself as "risking and taking chances" in her therapy sessions and that "if I don't know what is going on, I find out." Others may find themselves waiting until they are sure before making an intervention. Most therapists emphasize the importance of asking questions of their patients and all work hard to understand the patient's experience. Often the process involves relating the ideas back to oneself as a person, asking oneself what one would do in a similar circumstance. This process of self-reflection becomes an important part of using oneself as a person and in performing effectively as a therapist. It also has strong implications toward developing the necessary therapeutic alliances, for in the attempt to empathize and apply the experiences personally, it appears that a strong therapeutic rapport is created.

Grief therapists are sensitive to the patient's affect, often interpreting projections such as anger, disappointment, feelings of helplessness and hopelessness as these arise in the therapy sessions. There appears to be an attitude by all therapists to not be overly protective or overtly reassuring toward patients in grief, or to minimize the patient's own capacity to work with interpretations and incorporate change into their lives. Grief therapy is therefore not seen as totally one of supportive therapy nor as a means of rescuing the patient, or exploring, and expressing painful feelings. Instead, it is an opportunity to gain insight about oneself and one's own ability to cope even with devastating losses. Grief therapists are seen as generally fairly confrontive and direct. The supportive aspects of the therapy are sensed in the context of the total relationship rather than as merely a particular phase of the therapy. There is a sense of closeness created in the fact that two people are working through a time of crisis in the patient's life.

Part of the interaction between therapist and patient involves the need for the therapist to be able to "stay with feelings" that ordinary individuals might find surprising or difficult to tolerate. One therapist states that for her, the most satisfying aspect seems to be "in the ability to work with them through their pain" and that "pain and feelings do not scare me." This encouragement and tolerance of affect is one of the most important basic therapeutic techniques common to all the therapists. Another therapist describes grief as "a time in which our most basic gut feelings are laid bare." His approach is to help people build trust in themselves and in others and "help them connect with people in deeper ways and much more meaningful ways." His words imply that the intensity of grief issues require an acknowledgement of intense interrelatedness with people.

Grief therapists are also flexible in their attitude toward patients. One therapist says she listens to her patients, and allows herself to alter her views accordingly to what she learns from her patients. Thus, when she finds out from her patients, for instance, that society often does not allow people to talk openly about their grief, she looks for verification in her own experience. She finds herself reflecting back to when her friend's husband suddenly died, and she experienced other people around her hesitating to approach the grieving widow; now she can more clearly sympathize with her patients who also felt they had no one to talk to and who found society generally unresponsive and unsupportive of their display of grief. This therapist indicates that taken in theory alone, she might have continued interpreting people's fears and hesitancy to share their feelings with others as a defense. However, after her personal experiences, she not only could affirm the patient's reality, and validate their experiences, but also use her own personal experience to change her approach to her patients. Consequently, she found herself striving to "listen with a different ear" not only to what was being said, but also to what was not being said. Several therapists refer to the importance of "timing" as an essential part of the therapeutic techniques involved in the process of working through loss issues to arrive at a new developmental level, and which is defined by one therapist as knowing "when to push and when not to push" when making interpretations and interventions. It is evident that the interaction between therapist and patient must be very much in harmony, where the therapist takes his cues of whether to be supportive or confrontational, according to what he sees the patient can tolerate at any particular time. This implies the necessity for flexibility in therapeutic technique and keen awareness of what is best for the patient.

Each of the therapists show a respect for the individuality of their patients, and portray a nonjudgmental attitude toward them. There is an appreciation for the individuality of expressing grief for each person, as one therapist points out, "Mom may cry all the time. She expresses it quite openly. Dad may be so tight. His way is not that. He may run with the dog all the time. That's the way of saying I hurt so much, get it out." Part of the intuitive aspect of grief therapists is to be able to read people's emotions, interpret the pain behind the affect, and above all be comfortable with the expression of emotion. The therapists look upon themselves as a "catalyst" or facilitator in the grief process always aware that the patients need to draw from their own strength.

Countertransference becomes a powerful tool in grief therapy and grief therapists use it effectively. One of the main countertransference issues that arise in grief therapy sessions, according to one therapist, involves how the therapist picks up the patient's feelings that someone should have been there for the dying person. Above all, it is the feeling of inadequacy and helplessness, and the sense that no one can stop the events from happening, nor can they rescue the patient. Thus, as the patient may be pleading, "How do I deal with this?" the therapist is forced to patiently wait and let the process of healing take place for the patient. One of the challenges for many therapists is in picking up the patient's desire for comfort or to be rescued. For some therapists their feeling of competence may be challenged, as there are never any easy answers to offer and yet the impulse may be there to attempt to rescue the patient from their pain and offer reassurance.

Of particular value to the therapist is the ability to help their patient "reach out to others in new ways that they never thought possible before." This therapist points to the fact that the process of "working through" the grief involves affirming the person's worth and capability in helping themselves become stronger. She also indicates that she helps people in the ways that have been most meaningful to her: being able to make the most of oneself, and ultimately aim to help others. She emphasizes that her patients are an inspiration to her; from them she feels she has grown as a person and become stronger as an individual because of seeing others struggle and survive. Her approach to her work is "that nonjudgmental spirit and always that invitation that you can always be the best that you can be."

The therapists indicate a confidence in their ability to handle the issues that arise in the therapy session, and several point out their decision to take chances as they do therapy. This, as well, is turned back toward the therapist's own experiences, as indicated in the following therapist's explanation:

> How I felt when that happened . . . Taking that jump, taking a lot of chances in doing therapy and imagining how it would have been. That's my philosophy of doing therapy, risking and taking a chance. You can fall flat on your face or survive. I think my approach to therapy is very much to take those chances . . . if I don't know what's going on, I want to find out.

It is evident that this attitude indicates a strong sense of individuality and curiosity, yet sensitivity to people's feelings. As well, grief therapists tend to not be afraid to use themselves as a reference point in their interventions and ideas. As one therapist explains, "I think it goes back and forth. I do think about what I would do in that situation, and what have I got that is similar." However, in that process, there is no indication of the blurring of boundaries between therapist and patient.

Grief therapists indicate that part of the technique involved in doing their work involves asking themselves what they would do in a similar situation to their patients. It is apparent that therapists do not tend to be overly critical or even directive toward their patients, but mostly focus on trying to understand the patient's experience. In the process of trying to personalize the experience that the patients describe and to empathize, the therapist finds themself looking for parallels from their own past. This involves an attempt to "find some sort of common ground." One therapist indicates that this process comes more easily to seasoned therapists as opposed to the less experienced, for while at the beginning of her career she found herself having to "struggle" as a more experienced therapist "it came much more naturally." She indicates that basically with grief patients,

> I look hard to find the middle ground with people who had losses. I think that's part of the work we call countertransference, the sense of feeling inadequate and that's part of where the anger is, when you're working with people who you don't know what they're going through, you feel sort of helpless and sort of useless.

She states that it is easier for her to do her work when she can empathize with her patients, and that empathy comes much easier with loss and grief issues than with other therapy issues. "It's easier for any therapist to identify with the patient because in some way or another they too have experienced a loss, even of an ideal or something. Where they might get in trouble is they might not want to look at it." A similar point is made by another therapist who states that she too values what she learns from her patients and values the interaction that is part of the process:

> I really learn as much from you as I have done for you. You teach me how to live and how to be for other people. And I get another example of how it can be done, so that the next person I go to, for example, who has a child who has been murdered, I can say, look, we have cases in point where it has worked.

Thus it is clear that the process of the therapeutic technique with loss patients involves reflecting on oneself, and using one's own experiences and ability to empathize with the patient. Grief therapists utilize their ability to empathize in individual ways, however, some choosing to be open and candid about their personal experiences with the patients, and others keeping this process of identification an internal one, but one which is manifested in their empathy and connectedness with the patient.

Emerging Self

As the relationship unfolds in the process of the interaction between the patient and the therapist, and as the therapist uses their past experiences and integrates their sense of self, a self "emerges" which appears to be a culmination of previous influences, but which is also "changed" or indicative of a heightened self-awareness and capacity for interrelatedness. The emphasis in this phase is focused on the capacity to be self-reflecting, and self-revealing, using self-disclosure to heighten and enhance the sense of self. It is also this "emergent" sense of self that is capable of making the most powerful impact on the relationship with the patient, for it is a culmination of a striving for interrelatedness with others as well as ultimate appreciation and valuing for one's individuality. The following will be a discussion of some of the salient aspects of the emerging sense of self that the therapists indicated were particularly reflective of their values and self-concept as therapists and as people, and which further enhance their work as grief therapists.

Identifying With People

Grief therapists appear to consider empathy not only particularly essential in their work, but actually sometimes easier to acknowledge with loss patients, since losses are universal. One therapist states, "everyone can identify with losses in life, whether actual or symbolic." This is in contrast to other areas of therapy which may be more difficult for the therapist to fully understand personally, as explained in the following:

> I think every change is a loss. But I think the issues of loss are so broad. It would be hard not to identify with what people are going through. I may not respond to it necessarily. It certainly gives me an insight into how I have dealt with losses in my life. And I've used that life experience. Everyone has had loss experiences, so you can really guess a lot. I think it's more difficult to find that middle ground when people come in and have had sexual abuse by a father or been in foster homes. I have not been through that, so I have to try to imagine what it's like to have that betrayal of trust. Someone who's gone through a loss, or an experience where there has been a death, I can empathize more effectively.

Her comments point out the dilemma faced by many grief therapists: how can one fully appreciate the complexities of the patient's feelings unless the experience has been lived personally? All the therapists agree that with grief issues, there is already a unique level of understanding between therapist and patient, for life experience naturally involves loss at some level.

Empathy involves the ability to put oneself in a position of the patient and make the necessary emotional connections with the other person. As therapists have the courage to examine their own losses, it seems they can begin to make deeper connections with their patients through the use of their "emerging" self. Furthermore, throughout the grief process itself, the therapist may experience being a "lost object" to the patient, for when the therapy is completed, the relationship is "lost" and likely over forever. Grief therapy is therefore unique in that it provides an opportunity for the individual to focus on loss, to repeat that experience with the therapist as part of the therapy, and perhaps to redo that experience with gained personal awareness and insight. At each of these levels, the grief therapist plays a very active and crucial role.

Not all therapists are comfortable with the concept of "identifying" with their patients. One therapist states that he does not deliberately identify with his patients, although he acknowledges that that may be one means of acquiring empathy. He explains:

> I'm not aware of trying to identify, I guess I don't separate trying to identify, with empathizing with them. I don't try explicitly to identify, but I have to use my experience to understand their experience. That process is always there. I don't think I would have to have losses to work in grief therapy. I mean I did it before I had my own personal losses. But certainly the quality of my understanding of someone is quite different, I think . . . in that just the more life experience you get the more well-rounded you are in how you can look at things.

Instead, this therapist, expresses his sense of empathy by referring to his "curiosity" in people as he points out in the following:

> I'm not afraid to talk about myself a little bit in my interviews. Not in a big way, but I will let people know if I have had that experience. I don't make a point of doing that, but if it seems natural I certainly will. And I think that comes through in how you empathize. That's the basis of empathy in my way of thinking. I have curiosity about people, how they work and how they make sense of things. Curiosity is a quality that is valuable because someone may tell me something or have an experience that I just don't understand. So curiosity motivates me to listen for what they're saying by not saying it or what's behind their experience that they're not saying or unaware of even. I don't have to have answers right away, but I try to understand.

While there is some appreciation and recognition of an increased capacity by therapists who have been through equivalent losses as those of their patients, no therapist is adamant about the necessity of having to go through losses in order to be an effective grief therapist. In fact, one therapist points out that countertransference issues within the therapy session itself can be used effectively as a tool toward empathizing with the patient. Feelings of helplessness and inadequacy experienced by the therapist can be seen as projections of the patients' own internal world as they struggle with their losses and explore their own vulnerabilities to death, as explained in this therapist's words:

> When you look at people who are grieving, at least for me, if you look at the anger–I could feel the anger, partly the anger being projected on to me. But I think it's also part of the feeling of total helplessness. That there is nothing you can do about this . . .

Thus, the importance of empathy is found in its use as a dynamic process between therapist and patient, where the therapist is constantly reflecting back on what they have experienced, and using their feelings to better understand the experience of the patient. When the therapist starts to experience these feelings in themselves, it not only opens up an opportunity for crucial self-analysis for the therapist, but also an opportunity of becoming closer to the patient's internal reality. The capacity for empathic interaction with the patient appears to be enhanced in the phase where the self emerges, for then therapists have a keener awareness of themselves as unique individuals, and thereby are able to relate and empathize with the patient more intensely.

Another therapist very clearly describes her approach of working with patients, through the metaphor of being a "wounded healer":

> the therapist part of me is the places where I've been and where I've done my healing. And that's what I share with people . . . it's a very human approach. I have my stuff and they have their stuff and we're all in this together. And I can only take you as far as I have gone in my own healing.

This therapist's approach is basically to affirm: "I too have lived through what you are describing." Thus, empathy is part of a dynamic process between therapist and patient, where the therapist is constantly reflecting back on what they have experienced, and using their own feelings to better understand the experience of the patient.

The rapport between therapist and patient is a fundamental element in successful therapy. A grief therapist's own personality, style and personal choices are reflected in how they establish rapport with their patients. Some of the therapists emphasize the importance of establishing an initial rapport with patients who are grieving by incorporating personal touches in their offices in order to make it comfortable for the patient and conducive to grief work. One therapist emphasizes her attempts to make the patient feel respected and understood as an initial and essential first step in the therapy. In fact, she stresses that one of her personal strengths is found in her ability to relate to the "everyman" and she even says she catches herself adopting a "chameleon-like stance" with her patients when she sometimes takes on their characteristics, mannerisms and vocabulary, as she explains in the following:

> I'm fairly confident about who I am. Sometimes insecure . . . But I think my biggest strength is that I think about "everyman." There used to be a concept about "everyman" or the common man. I think I relate pretty well. I even surprise myself. When I talk to someone who is fairly rough, like I find myself using language that I wouldn't use. And sometimes I think that seems to not be a deficit.

This therapist also emphasizes that her personal approach is in initially "engaging" the patient. This involves making them feel comfortable and respected, as they "need to feel that you do know your business. That you are competent." Near the beginning, the emphasis is on "helping the individual feel comfortable, good about themselves, and good about being here." This emphasizes also the importance of sincerity, and of being "as real as you can be with people, instead of putting up barriers or fronts with people" and thus requires that therapists have a definite sense of who they are, which involves awareness of the emerging self. Therapists emphasize an attitude of acceptance of the patient portrayed by how well they listen to them. Simply stated: "just listening very carefully may become the first step to establishing the necessary rapport in grief therapy. Thus, grief therapists use themselves as an integral component in their work. There is an emphasis on authenticity and honesty as well as on objectivity, and in the case of the therapist, a clear sense of oneself. It appears that a balance can be arrived at between using one's own personal qualities and being aware of the necessary boundaries needed for the therapy process.

Being Present

One of the recurring themes that each therapist refers to is that of the significance of the therapist's presence, or of simply "being there" for the patient–that somehow in the listening and physical presence of one human being making themselves available to another person, there is a definite therapeutic effect. This concept is exemplified by one therapist as being a culmination of her own introspection, awareness of her personal losses, and ability to "be present" for people. She regards her "presence" as involving being supportive, recognizing people's pain, and her own ability to present hope, for "there's always possibility, there's suffering but there's always potential to reintegrate at a much higher level than you were before." It appears then that one of the personal characteristics for the grief therapist is an awareness and appreciation for using themselves in the therapy, even if it simply means letting oneself be available physically to listen to another person who is grieving. This role is seen as an active one, not passive nor negative: it involves listening so as to experience a definite valuing of the other person.

For example, one therapist describes how a friend, just by her very presence, by taking long walks with him, listening and gently questioning him, had a particularly powerful effect on him, as he was attempting to work through the loss of his father. A person "being with" another is seen as a central component to the healing process. Also, as this therapist points out, "a very special bond was established between us as I really came to trust her very deeply . . . and this also changed my ability to trust, and to trust myself." It appears that part of the process of coming to trust others and oneself involves an opportunity to "really listen to someone and try to understand where they are coming from." This indicates that the technique is very much tied to the relationship between the therapist and patient. Ultimately for the therapist, as he points out, "my learning is from my clients."

One therapist interprets the "gift of presence" as a confirmation of her belief that people should not die alone. In fact, to her, "it is easier to be involved with the dying person than shunted into the hallway." She describes her own personal experience of her mother dying and the entire family, including her young son, being involved by visiting their grandmother, massaging her feet, talking and singing together, and spending the last days by her bedside. As she contemplates her own death she requests that her family allow her to be at home with them, take part in the family interactions, and above, all that she have the children around her. The value of the human contact seems to have no comparable substitute. It is also evident that the death of someone close brings to the forefront feelings and fantasies about one's own death. To this therapist, then, the emphasis is also on being with others, and in not going through the final stages of dying alone.

This focus on "being" appears to present to the grief therapist a special challenge, particularly in the area of professional boundaries and patient-therapist relationships. Perhaps because of the intensely emotional nature of the topic of grief that brings the two individuals together, many therapists interviewed either make direct reference to, or imply some concern about the dual relationships that are often tempting in this field of work. For instance, some therapists appear to encourage an attitude of "friendship" to describe their relationship between themselves and their patients. Whether this is specific to grief therapy more than other areas of therapy is uncertain, but the interviews do indicate that grief therapists prefer to work collaboratively rather than merely address relief of symptoms in the patient. Particularly for individuals who are undergoing "uncomplicated bereavement" rather than pathological bereavement, there appears to be some tendency to regard the relationship more as a supportive and "give and take" rather than a strict adherence to rigid professional boundaries and distance between therapist and patient.

Being present for one's patients may also serve as a way of saying to the patient that they can be "present" with themselves. Several therapists refer to their attempt to "normalize" their patient's grief experience, meaning that they acknowledge the patient's experience and attempt to validate the person's experience rather than attempt to "change" the person's perspective. Part of this process involves the role of listening to the patient, with an attitude that what they are going through is a perfectly human reaction to perfectly natural events. They are not approached as a pathological population, although it is uncertain to what extent the various therapists work with differing pathological cases. However, it is in this interpretation of what is considered "normalizing" that may lead to possible crossing of therapeutic boundaries. Some therapists extend as part of their therapy contact a social element for the patients, such as holding a pot-luck supper or attending other social events outside the strict therapy setting. For them, this fits into their definition of the therapeutic structure of sharing and building a sense of camaraderie, as well as a sense closeness and caring. It is possible that for some grieving people, such an opportunity of sharing might be the closest they have felt to other people since their loss; the interaction offers an opportunity to value and cherish new people and relationships as they move on in their lives. The rational for some grief therapist's techniques appears to be to avoid a standard therapeutic contact and instead gear the therapy to the individual or group involved. It is the relationship itself which is viewed as therapeutic, and the work can take place on various levels and places with a "community spirit" of helpfulness, and with the sense of a shared human experience.

While most of the therapists do the majority of their grief therapy with individuals, some have experienced that group therapy is an effective means of working through grief issues and offers a unique potential for the therapeutic effects of "presence" and for the "emerging self." In the group setting the notion of "people in relationship" stands out as an important and powerful therapeutic tool for as one therapist points out, "by our nature we are always in relationship." Her own personal preference for working in small groups is because "you get such a fellow-feeling, a kindred spirit . . . as you heal you can in a new way give healing to others." The process of therapy is thus one of providing a milieu where people can inspire each other and come to the important realization that they are not alone with their grief. Furthermore, there is a sense of strength that comes from an awareness that no one's problems need to be overwhelming, and so that in contrast to the individual who feels that no one could possibly understand his pain, in the group setting it may be easier to come to see that, "There is none that is too bad or too horrible. We are all human beings." Group allows the opportunity for people to learn from each other, share their feelings and give understanding and acknowledgement to each other, with the sense that everyone simply experiences differing variations on the same human themes. Each therapist indicates an appreciation and valuing of the importance of people relating to each other. Some emphasize the importance of relationships between therapist and patient, and others the effectiveness of interaction between peers and in a group context. The focus of the emerging self, whether in group or individual therapy, is on the powerful use of the interaction between people which can to contribute toward healing emotional wounds.

Therapeutic Boundaries

Some therapists in their choices of "being present" choose to work with more clear-cut boundaries between the role of patient and therapist, where the relationship is restricted to the confines of the therapy setting. One therapist even indicates that one of her biggest mistakes as a therapist was in attempting to turn a therapeutic relationship into a social relationship when she consented to have dinner with a patient after the therapy contract had terminated:

> I've had clients say, "let's get together, you know, after." I had two clients. One was a psychologist and one was a social worker. And so, both were women my age roughly, a little younger. There seemed to be a lot of ground for commonality. And they said "let's get together," but it just didn't work. We couldn't change, we couldn't get out of the roles and change the format, and so what it ended up turning out to be is a therapy session over dinner. And that's hard work, and that's not how I like to spend my free time. A friendship is based on exchange. And so a couple of times I guess I tried to handle termination that way, by not terminating, but by changing the nature of the relationship. However, I found that that never worked for me. But I have clients who still keep in touch, sort of off and on from time to time. That's quite nice.

She came to recognize that while the patient might have received some gratification from the experience, she found herself unable to fully make the transition from role of therapist to that of friend. It appears that while clear-cut roles between therapist and patient are seen as not only more satisfactory but also essential for maintaining an ongoing therapeutic relationship, the human contact is nevertheless greatly valued.

The preference and choices a therapist may take to being "present" to the patient are often determined by their theoretical orientation. Thus, one therapist schooled in the psychoanalytic approach, with no encouragement of extra-therapy contact, found herself reluctant even to respond to personal letters sent to her by former patients:

> When I was an intern in Montreal they gave us all the borderline cases. Several of them found out where I was working and wrote me letters and I never wrote back. And I really regret that. That's something I wish I had done. I wish I had written and replied to their letters. I've been trained so hard in the psychoanalytic school, it didn't even occur to me. But the loss of me as a therapist, and they missed me. I didn't appreciate that.

She comes to later feel a sense of regret that she interpreted the boundaries so rigidly and did not extend this common courtesy of keeping up a slight contact with her patients and acknowledging the loss that her patients experience, of her, as a therapist and as a person who was important in their lives. She indicates that she learned through this situation a greater appreciation and awareness of the intensity of attachment that some patients develop with their therapist. She also realizes that her approach does not deny her awareness of the effect her patients have on her too; she emphasizes that her patients often touch her life personally, even though they may be oblivious to this. She says she also tries to incorporate into her own life what she learns from them. Thus, a dynamic process is taking place, whereby even without the patient's awareness, the therapist is constantly learning from the patient, and the relationships is extended beyond the confines of the therapy setting as the exchange continues, contributing to the therapist's knowledge and personal growth. It is even possible that because of the focus on grief as the primary issue, and the emotional nature of this subject, there is the groundwork for a mutual understanding that is rather unique compared to other areas of therapy.

Another important aspect in understanding why therapists may handle boundary issues and self-disclosure so differently can also be attributed to their differing personalities. One therapist describes her attitude to her patients with a metaphor of attempting to stay "one cell thickness away from the patient" and with "one foot planted in the muck and the other on solid ground." In other words, she attempts to feel the patient's pain, is open to the other person's experiences, and therefore makes the necessary connections with the person. However, she sees her role as not stopping merely at an empathic stance, but rather as functioning to some extent as a role model to the patient, exemplifying to the patient someone who has survived grief herself. Thus, she also does not become consumed in the attempt of comforting the patient. The emphasis seems to be on valuing the nonjudgmental attitude toward the patient, allowing them to grieve in the way they feel comfortable, being able to tolerate whatever expression of emotion arises, yet still keep oneself sufficiently placed in the reality of the situation with the awareness that it is the patient who is grieving, not the therapist. Through this interaction, a bond seems to develop between therapist and patient. As one therapist indicates: her therapy technique is strongly influenced by her own therapist/mentor who "loved me through stuff I thought was unspeakable" and which she in turn strives to provide in her own approach to her patients. It is evident that relationships between the therapist and the patient can be interpreted differently by various individuals, and is largely affected by the therapist's own personal preferences, personality and theoretical orientations. One commonality among all the therapists in this study remains, however. That is, a strong adherence to ethical considerations and an attitude of respect toward their patients.

Self-Disclosure: Directly Using Oneself in the Therapeutic Process

It appears that self-disclosure with patients often reflects the preferences of the therapist and the way they choose to work. While some may disclose much more than others, all seem to recognize the necessity of establishing a sense of balance. One therapist admits that her work with patients who have had losses does trigger thoughts of her own losses, but she is strict about "not burdening" her patients with the details of her own life. Rather, she tries to "identify" with her patients, and "compares" herself and her own experience with them, and the attempts to utilize the insights in her own life, as well as try to help the patient do the same.

Many of the therapists use self-disclosure in their therapy sessions as a means of improving the therapeutic alliance, helping the patient feel understood, and enhancing the sense of closeness and trust. They are also, however, very conscious of their position of power in relation to the patient. One therapist even referred to how much easier it is to be honest and confrontive as a therapist, telling people what you really think when sitting in the "big chair" than it is when interacting as an individual in a personal relationship with family members and friends. Another therapist refers to her sense of "getting my buttons pushed" in the therapy situation, thereby being open to using her own feelings and herself as an instrument in the therapy in order to better understand the patient and to be authentic. For four out of five therapists in this study, there were in fact indications of clearly using personal disclosures on the part of the therapist. References were made to crying and to laughing with the patient, acknowledging when the therapist themselves had a similar experience as that described by the patient, and offering a mutual sharing of loss experiences. The exception occurred with the therapist trained in the psychoanalytic perspective. She indicated that she did not make a point of overt self-disclosures, but she stressed, as did all the therapists, that an internal process was occurring, where the patient's experiences were constantly evoking her own personal experiences. Her choice to not share them openly with the patient was rationalized on the basis of allowing the patient full rein of their feelings, without digressions instigated by the therapist. The therapist, however, appeared to not be any less involved or attuned to the patient's feelings.

The rationale behind the use of self-disclosure appears to be that patients feel better understood if they know that the therapist truly understands them and has perhaps even survived similar experiences. It seems that self-disclosures for many work as a form of emotional shorthand which help develop a bond of trust between therapist and patient. This is evident as one therapist describes how a visit by a minister left her feeling somewhat alienated until she learned from the minister that he, like herself, had also lost a child. Only then did she feel totally understood.

> I remember our daughter, when she died, and we were preparing for the funeral. The minister came to our house, and God was not exactly on my Christmas list at that time. And I shook his hand and then he said something about not making any hasty decisions about where you want to bury her or how you want to do this, because we had our son cremated, and seven years later when we moved back to Nova Scotia we buried him there. I said, "Your son died?" And he said, "Yes." And I said, "Can I shake your hand again, because now I know you understand what is going on with us." And there is an empathy and an unspoken word among bereaved parents. And I know because I've dealt with hundreds of them, that simply because you say I too am a bereaved parent, a bereaved person, that gives you a tremendous amount of rapport and credibility to someone who is in the same shoes. And I learned that you never say, "I know how you feel" because grief is not a contest, and I hurt more than you do and that you must not have loved them as much because you are grieving less and it isn't that. It's just that we demonstrate it in different ways. Any way to grieve is okay as long as it doesn't hurt yourself and it doesn't hurt anyone else . . .

Her situation highlights how the therapist who has experienced grief personally, and then functions in the role as the professional, offers a particularly powerful means of helping the patient. This offers an opportunity for the use of the self: using one's own losses to make deeper and more intense connections with the patient.

A therapist who was adamant about never self-disclosing about her personal life to her patients nonetheless admitted that privately she consciously makes parallels between her patients and her own life experience constantly. She finds grief therapy particularly powerful in the sense that everyone can identify with a loss of some sort. Thus, it seems that even when grief therapists may not choose to openly share their personal losses with their patients, they nevertheless use a process of thinking back to their own experiences, and considering how they handled similar losses or feelings. Grief therapists appear to use themselves as an important reference point for helping the patient. If self-disclosure is sometimes indirect, it is present subtly, for the therapist is drawing very much from their own life experience and using that as a means of interacting and connecting with the patient.

Therapists who indicate that while they sometimes do choose to talk about themselves in the therapy session at times, are careful not to take the focus away from the patient's issues. Some see some self-disclosure as a very useful therapeutic device:

> It's the therapist as a person. You use yourself. And if you believe in I-Thou relationships and empowering people, then you can't pretend that you're all together, because then how does it feel. You have to be together enough to be therapeutic. Obviously you need to be solid and strong. But you can't be so strong that you are untouched.

This therapist recognizes that she/he may still have unresolved issues, but attempts to use this to the patient's benefit by "watching myself so that they don't get in the way . . . And trying to pay close attention to my own issues so that I'm not sort of playing those out instead of the clients' issues." While being aware that certain personal issues are still unresolved, the focus becomes one of doing what is best for the patient. Thus, when the subject of grief does bring up feelings of sadness within herself at times, she sees this as an important step toward working through the feelings as both a patient herself and as a professional focused on working with others. Basically, the attitude that most therapists adopt is to let the patient do the work they feel they have to do. As one therapist clearly states, "I think you can empower people by listening to them and to what they have to say, and trusting that they can figure out what they have to do. And all they need is help and support and the right questions . . . trust the organism to know what it needs."

One's Answers Must Come From Within

All the grief therapists indicate a belief in "the capacity within each person to do what they need to do," and for "allowing the patients to find their own way." It is the patient who gets the credit for doing the work in therapy. Just as each person has the capacity to grieve in their own way, so each person must be allowed the opportunity for the healing process to occur. One therapist states, "We laugh and we cry and we treasure. Each one is unique . . . each of us has the capacity to do what we need to do." Her statement indicates the importance of recognizing the personal nature of grief therapy, that there is no set agenda nor a system of techniques. Just as losses affect people differently, so people must be allowed to work through their losses individually.

Grief therapy therefore appears to involve an important balance between support and of working together, and a sense of respect for one's autonomy and independence. The grief therapist recognizes the balance between assisting the patient, and of letting the patient grieve and work through this losses in his own individual way.

Some of the therapists appear to be concerned about not encouraging a sense of dependency by the patient upon the therapist, despite the intense feelings aroused in grief therapy and the vulnerable emotional state of most grief patients seeking therapy. Grief therapists often speak abut how their approach to grief therapy focuses on helping the patient find their own internal strength to face and deal with their losses. One therapist says she works by "stepping aside and watching the person fall" rather than allowing them to "cling" to her. The emphasis is in helping people realize "they have everything they need inside of them." Thus the role of the therapist becomes one of facilitating or helping the patient access their own strength, and not simply to look to the therapist for guidance and support through a difficult time of crisis.

Grief issues often occur in a normal population, with people capable of recognizing the limits of the therapeutic relationship. However, one therapist describes one of his more unfortunate experiences which occurred when a patient became overly dependent on him. He takes some sense of responsibility for the situation, in that he offered grief therapy, perhaps inappropriately at the time, to an individual who had various other deep-seated personality disorders beyond her grief issues:

> I was trying to do grief therapy with someone who had a lot more issues going on than just the grief. I'm more sensitive to that, more now. Before I was not so aware of having grief and loss issues in perspective. That particular situation involved a woman who lost a mother and she formed a very intense attachment to me. That time I saw it as a really wonderful relationship and that she was really going to go places, but she was really very disturbed in her personality style. I wasn't able to read the signs of that. I got involved in a very trying relationship where certainly we made some progress at great cost to me in terms of suicidal threats and wildly impulsive suicidal gestures. And then the attachment was such that I couldn't easily disengage from it. It wasn't appropriate for me to have started dealing with her in the kinds of things I was. So that was my lack of experience and not enough knowledge . . . I learned the hard way.

To the majority of patients, however, he believes that they view the therapeutic relationship as follows: "You're like a rock that they can attach themselves to if they need it for the time." Also, despite the availability and the closeness of the relationship, the patient is always encouraged to find their own sense of hope. Each therapist emphasizes that it is the patient who must find their own personal strength for themselves and that this cannot come from the therapist alone or be obtained externally. Rather, as the patient recognizes and utilizes their own inner resources, the changes can be lasting and meaningful for them as individuals. The role of the therapist remains in being the facilitator for the patient's own internal journey.

Given the philosophical stance, then, that "one's answers must come from within," it is not surprising that all the therapists down play their position as "experts" in their approach to doing therapy and emphasize instead that the patients themselves know their own experience best and are thus the only experts for themselves. While it may, therefore, be tempting for therapists to instruct and guide and perhaps to support their patients, it is evident in all the interviews that these therapists believe that the patient has the capability to "find their own answers" to understand and accept their feelings, to learn about themselves, and to learn more about life. Clearly the role of the therapist is not seen as being so much that of the expert, as of a compassionate and steady companion, beside the patient through the process of introspection and expression of grief. This is expressed by the following therapist.

> Early on . . . I must have read Kubler-Ross . . . and her emphasis was very clearly one of "letting the patient be your teacher" . . . . And it's been very valuable for me and still is that I don't have to be the expert, in fact that it doesn't help to be the expert. Basically the person who is in front of me is the expert in their experience. I'm not, they are, and if I forget that I can really get in trouble. So, to really listen to someone and try and understand where they're coming from is really essential. Where a lot of my learning is from is from my clients.

Most therapists emphasize that their work involves not so much having answers, but of asking the right questions, and they rely greatly on their intuition as well as on their own experiences, and then partly on their theoretical knowledge and skills. Ultimately, they recognize the power behind "using" themselves to better relate to the patient.

Thus, grief therapists use a combination of their own personal qualities and intuitive ability to connect to people, as well as their own understanding about grief therapy and various techniques to help the patient with their mourning. Ultimately, however, it is the patient who finds the strength from within to cope with the loss. It appears that as the therapist listens to each individual's experiences, a connection between the therapist and the patient takes place. The therapists in turn appear to internalize the insights they gather from the patient, and focus on the similarities they can see in their own lives. In many ways, then, it is a relationship between two people having a dynamic interaction, with many internal processes taking place within the mind of the therapist, even though their primary role is that of listening and guiding the patient toward finding his or her own answers.

Recounting the Life Story

It is evident that the concept of the "life story" has two major emphases: one as a philosophical approach for the therapist who can then better appreciate all the various dimensions of experiences both positive and negative, and put them into a useful perspective. And also as a way of relating to the patient, with the attitude of a genuine appreciation of the patient's unique story. There is an implication as well that in the therapeutic setting, merely the telling of the life story itself has an effective cathartic healing function. Both the hearing and the telling of the life story is therefore a means of connecting to the patient, and perhaps providing them with a cathartic experience. It is also however, a stance which emphasizes respect and patience offered from the therapist to the grieving patient, where both, it appears, experience a healing effect.

Therapists are often touched deeply by the accounts of their patient's experience and feelings. For example, when one of the therapists saw a patient who survived a motor-vehicle accident and heard her describe her feelings of guilt and pain, the therapist found herself applying the lessons to her own life:

> a beautiful girl . . . came to one of my self-esteem workshops, and on the evaluation form she wrote: "I came unable to swim, and I leave unable to drown." This girl had driven her car into a train engine. And her good friend beside her was killed, a child in the back seat was killed, and her unborn baby had died in that crash. And as she said, "everybody blames me."

The closeness that is established between therapist and patient through this cathartic activity of recounting the "life story" seems to be part of the healing that occurs in grief therapy. One therapist refers to the "sacredness of one's life story," implying that part of its significance is in the fact that one person (patient) shares their life with another person (therapist), and that through the encounter there is a valuing of one individual for another.

Each therapist makes reference to exceptional patients who have touched their lives. One example that can be highlighted is of a young woman with leukemia who had learned her own way of coping with pain and who maintained a strength of spirit that was inspiring to her therapist:

> This young woman, a 17 year old Chinese, leukemia . . . they did a bone marrow transplant and she was just incredible. And she really stands out for me . . . she and I established a good relationship. She lost all her hair. She had this beautiful face and this perfectly round head . . . and she used to sit in a lotus position, and she looked for all the world like a Buddha. And she was very stoic and she taught me a lot about never presuming there are right or wrong ways for someone to deal with anything. People find their own way. The best you can do as a

> therapist is let people find their own way, and be there and supportive. Like if it's asked for and it's appropriate, offer alternative ways to look at but, but never presume that your way is the right way. She had a number of spinal taps. And they're very difficult. And she would become very annoyed. And often they were done by a resident. And he would, when he was doing one, try to distract her. And what she had me do, because she found it fairly difficult to communicate with people she did not know, because she was quite young and she, she said, "would you please ask them not to do that. If they're quiet, then I just go on to my own place. But if they talk it keeps bringing me back." And I thought she had developed her own strategies to deal with things that she had to deal with, and her way was obviously the best way. She just taught me a lot.

From this example, it is evident that the patient's account of her experience or "story" offered greater insight to the therapist, who felt she learned through the encounter with the patient about her own coping mechanisms. Thus, patient and therapist share insights, one learning from the other. Another therapist came to value the notion of how interconnected people are to one another, which also becomes emphasized in grief therapy, for as she points out, "when one single person dies, numerous people through their various relationships with that one individual, are affected. Thus, a husband loses a wife, children lose a mother, and parents lose a daughter, all in that same person." This insight helped the therapist to better appreciate the extent of her patient's losses, for in one individual, so many can be affected.

The concept of the retelling of the life story in grief therapy can be considered as part of a large spectrum. One therapist explains show she views life as a flow and a continual process of learning about oneself and working through one's personal issues. She says, for her: "My past is my history; it is my life story. It's rich in early learning and in influences, in memories, in understanding, in experience of how I handle certain situations and what has worked and not worked." She indicates that even with the important focus on hearing the patient's story as a part of the therapy, the therapist is also directly participating by applying the insights and parallels of the patient's story to the therapist's own life.

The retelling of the life story assists individuals in making connections between their past and their present, and to reflect on how they can learn from their previous mistakes. One therapist quotes a phrase which struck her when she once visited a concentration camp in Germany and read the sign over the gate: "Remember so as not to repeat the past." This can be effectively applied to grief issues, for as this therapist states: "We need to look at our losses. We might name them and perhaps get forgiveness, where we need, to get rid of bitterness that holds us back. And you can get a healthy acceptance of the past which is wonderful." Many grief therapists recognize the great value found in looking at the past.

An important aspect of the retelling of the life story is also in looking forward, and considering future events and goals: "Our dreams and our long-range planning" offer an opportunity to plan out and to live in the way people choose to live and relate to one another. One therapist uses the insights she gained from their patients, to conclude, "in my future I can say there really are some things I want to say to my father who is still living, and I better get them in before . . . so I can look to the future and make some definite plans to do them." A similar step is taken by another therapist, who after hearing often from her patients the regret they had for not telling their parents how much she loved them, before they died, made a special point of approaching her own parents and for the first time, openly expressed to them her deepest love and appreciation. It was an important personal step, but an insight she learned from hearing the "life story" of her patients.

Another therapist points out her work in grief therapy has allowed her to see "life as a flow" and an emphasis on the continuity of all changes. Thus, all life events such as aging, are integrated into the flow of life and death, and she finds that this opens to her the hope of greater possibilities as she looks at each loss as a "calling forth into a new phase of life." It is apparent that she had exemplified an aspect of the emerging self in grief therapy.

I Gain More Than I Give

Perhaps no other concept is emphasized as emphatically and in such diverse ways as that of seeing that the therapist as a person gains as much and perhaps in some contexts more, than the patients with whom they work. Grief therapists utilize this sense of reciprocity that comes out of their work. One therapist points out about her patients, "they teach something so rich in that handling of the suffering."

Each therapist can point to not only many specific personal insights they gain for themselves through the contact they have had with their patients, but also sometimes important philosophical insights. One therapist says she feels that her patients taught her "to not be afraid of the pain and suffering" which contrasts to her upbringing, where the attitude was of emphasizing a sense of dread and an attempt to deny that anything good could come out of death:

> We were of German background, and there was a type of heaviness, of suffering, of this life was a veil of tears, and in the next life there would be happiness. And this life is not. And I kind of had this feeling that it's awful, that suffering is so terrible. So what they had taught me and what my own philosophy and theology had put together is that, yes, it is painful, and pain is always personal and unique . . . and that you can work through this pain and get a healing and come up with a whole new life. I think that emphasis I did not have as a child.

Her own perspective is then, that while an individual's pain must be acknowledged, it is also possible to get a sense of moving past it and growing from the experience.

One of the unique and rewarding aspects of grief therapy which is referred to numerous times throughout the interviews is the sense of valuing the opportunity as a therapist for being in close contact with another person and allowing oneself to be emotionally touched by them. It is evident that through this professional interaction a unique bond develops which extends beyond the therapy session. While each therapist can point to various individual patients who profoundly affected them, the following example emphasizes how one patient, early on in the therapist's career, touched him so deeply he redirected his life to pursue working as a grief therapist:

> I suppose things that stand out for me are some from early experiences . . . . I remember meeting with a middle-age woman whose husband was dying. I'm not even sure about that. It could have been that she was ill with cancer and she was dealing with that. It aroused for her some old memories for her of a close relative, I believe, of her father. I was just amazed at both the depth of feeling she recalled and that came forward in the present. And at the way those feelings were still with her and had an impact on the way she lived her life. The impact that that whole situation had had on their family situation, in terms of splintering the family, driving them apart from one another. At that point I was really a green, naive therapist. And it really stunned me to see, I guess, how powerful that was. The first flashes of wow, there is really something here.

This therapist tends not to emphasize the patient's pathological grief issues, but rather focuses on the patient as a human being who is struggling, who can be helped through an opportunity of being heard and understood, and who ultimately has the potential to find their own sense of strength. Grief therapists tend to discourage any possible attitude of being condescending which might easily arise out of a therapist/patient interaction, and seem to emphasize instead therapy process which involves "learning about life from the patient."

This concept of learning from the patient is exemplified clearly by one of the therapists who uses opportunities to include her patients as helpers in her grief workshops. She values their first-hand experience. While she says she is sensitive to the necessary boundary issues in therapy, it is unclear how she operates in a dual relationship as both therapist and colleague. However, to her it is the patient's "Ph.D. in life experience" that is of particular value. Because of the patient's actual experience in grieving personally, for some therapists it is thought that they can be especially effective in helping others, for they have actually "been there" first hand. One therapist describes how she was especially inspired by the generosity of a reformed alcoholic who is willing to be available as a support at any time of the day or night to someone who is struggling with alcohol. She also says that she has been tremendously moved by people's ability to help each other as evident in the following statement. "I think loss has the capacity to make one very generous if it's invited, if it's encouraged." I always say, "with a little help from our friends we can get by." It is evident from this example that grief therapists tend to approach their patients as individuals and fellow survivors and searchers in life. The pervasive attitude of working together, and helping the patient find his or her own sources of strength, appears to contribute to the important sense of reciprocity and rewards found in working in the area of grief therapy.

CHAPTER V

SECONDARY LITERATURE REVIEW: SELF-DISCLOSURES

This study has made reference to a number of characteristics which therapists have emphasized contribute to their development and reflect their sense of self. One of the areas highlighted in particular, however, is the issue of self-disclosure. This study has emphasized that effective grief therapists are highly aware of the power and the effect of self-disclosure, although they may not always choose to use it in the therapy sessions. One of the most important implications provided in this study is that the therapist's capacity of self-disclosure assumes an ever-evolving sense of self-awareness. This study has also shown the extent to which this issue of self-disclosure is a theoretical, research, and personal issue. For this investigator, the issue of self-disclosure offered a particular challenge, as it forced me to step outside the rigid domain of a psychodynamic stance of neutrality as a therapist, and to experience firsthand, the risk of reflecting on and sharing my own personal experiences of loss. Taking this step helped me actually live out for myself the experience that grief therapists constantly emphasize: using oneself in order to better understand and relate to the experience of others. The following will provide a brief literature review of the importance of therapists using, and being aware of self-disclosure.

Kottler (1991), writing about the qualities of successful therapists, speaks about the issue of self-disclosure as follows:

> There is no doubt that self-disclosure is probably the single most difficult therapist skill to use appropriately and judiciously. The therapist's revealing of self during sessions can be tremendously useful as a way to encourage a strong identification and mutual bond with the client. It is a way to model effective behaviors, to share instructive anecdotes and to close the perceived distance between client and therapist, thereby facilitating greater trust and openness. Therapist self-disclosure begets client self-disclosure. (p. 167)

Despite his obvious recommendation for use of self-disclosure, he nevertheless warns therapists to reveal themselves freely yet sparingly, always attuned to the necessary focus on the patient. He emphasizes the need for the therapist to know when to use this skill, and he indicates that it be only used when there is an obvious reason why another intervention cannot work just as well.

Self-disclosure emphasizes the inevitability of the therapists' influence on the patient. For those who warn about the centrality of maintaining a "neutral position" in therapy, the argument is that this influence should always be directed toward helping the patient acknowledge various aspects of their personality (Schafer, 1983). Kohut (1984) argues for the importance of the therapist to validate the patient's perception of reality, and to communicate to the patient that he grasps what the patient feels and demonstrates that he understands.

Opponents to the concept of self-disclosure have emphasized that "therapy can be considered as an intellectual process on the part of the therapist, and an emotional process in the patient" (West & Livesley, 1986, p. 19), with warnings about the fact that there is a danger of overidentification and countertransference issues arising toward the patient. They argue:

> therapists may experience a whole gamut of feelings during the course of therapeutic treatment; they must keep these feelings under control in order to maintain an optimum therapeutic atmosphere . . . therapists have to deprive themselves of the privilege of real relationships with their patients and concentrate instead on establishing therapeutic relationships. (p. 7)

The implication is that within the therapeutic relationship, the therapist must not attempt to gratify their needs, wants, and impulses, but rather to bring them under scrutiny. A study by Curtis (1982) on therapist self-disclosure even found that the greater the use of therapist self-disclosure, the less the subject's perception of therapist's empathy, competence, and trust.

It has been suggested that empathic remarks and therapist self-disclosure are offered in order to fill a void in the therapist when there is a lack of clarity, and in order for the therapist to not have to confront the fact that he does not understand the patient (Greenberg, 1986). Greenberg warns therapists about their countertransference reactions, especially when intense emotions are aroused by the patient, or in situations where the therapists feel similarly to the patient. At the same time, he notes that a therapist's fear of being intrusive in therapy may lead the therapist to sit with enormous amounts of information without engaging the patient.

King (1978) argues for the importance of maintaining an attitude of neutrality: "to wait without preconceptions for whatever our patient's communicate to us, whether through words, gestures, tones of voice, image, silence or facial expression . . . and to monitor our own affective responses to what is going on both between ourselves and our patients" (p. 330).

Among the hazards of a neutral stance, however is the fear that the therapist may appear as clinically detached. Tuttman (1987) for instance, encourages an empathic stance, without the propensity toward short-circuiting aggression and anger, and of interpreting projections and affects that originate from the patient. Proponents of therapist self-disclosure encourage therapists to be sensitive to themselves and to the variety of client experiences, not assuming what the clients are experiencing, and for the therapists to use themselves in their own experience as an indirect index of what their clients are experiencing (Elliot & James, 1989). Dean (1989) recounts examples where clinicians have done interventions with clients who have not been exactly "by the book" and yet it is these situations that are often felt to be most "real." An interesting finding by Berg-Cross (1984) found that negative affective experiences such as feeling belittled or diminished were always difficult or seen as inappropriate to disclose, and that therapists with longer experiences were more comfortable or utilized self-disclosure more often.

The importance of the collaborative relationship is often emphasized. Orlinsky (1989) found that the human qualities associated of empathy, caring, and credibility have a more consistent impact on patients than do the technical aspects of therapy. One study he cites points out that the strengths of the therapeutic alliance is mainly limited by the patient's pathology, in that the more disturbed the patient, the more difficult to establish and maintain a reliable alliance.

Simon (1990) points out that neutrality as a therapeutic stance, and therapist self-disclosure as a therapeutic technique are not mutually exclusive. In her study, she found that the main factors affecting therapist self-disclosure was the therapist's theoretical orientation, but other factors include the psychotherapeutic relationship, the therapist's personality, and the therapist's self-awareness. The following is a brief summary of her findings: high-disclosing therapist's agreed on loose boundaries between themselves and patients, espouse equality, are active participants in exchanges; low disclosers define boundaries, value neutrality, and are fairly inactive in order to encourage transference. Regarding the "real relationship," high disclosers adhere to truthfulness and genuineness, and fully disclose personal information, while the low discloser conceptualizes the "real" in terms of the actual person-to-person relationship, and "genuine" as being direct, attentive, respectful, and responsive to patients. Knowing oneself and valuing self-awareness and working in the transference was more a function of low disclosers. Her study also distinguishes between "counselling," which connotes a brief, less in-depth exploration with more emphasis on coping skills, and modelling, and "psychotherapy" which is considered as more insight-oriented, where self-disclosure might foster the alliance. She questions whether low disclosers may be excluding a useful tool of supportive and counselling work with some patients.

The use of self-disclosure in grief therapy has often been considered as adding to the intensity and depth that develops in this unique therapeutic encounter. Barcia and Ruiz (1990) point out that when two people meet repeatedly and alone, an emotional bond, whether positive or negative, develops between them, and that bond is intensified when one of the partners is grieving. Tirnauer (1984) indicates that as patients make changes in their personality, the therapist may experience feelings of helplessness with himself, or herself, that parallel feelings of loss.

Several examples are evident from the literature where therapists have allowed themselves to take risks and function according to what they felt was intuitively valid over what was traditional for working with grieving patients. Potash (1985) describes his experience of working with a former patient's husband, upon the death of the patient, showing how he made the difficult decision of transferring his allegiance from the wife to the husband. Lindner (1984) in his account of his life-threatening crisis concluded that the therapist's most useful tool is in his unswerving concentration on his own countertransference and the transference feelings of his patients. Carter (1991) sensitively portrays how her work with patients inspired her to approach her ailing father and address the emotional issues between them that had been previously remained unresolved. Weiss (1987) and Stern (1985) give accounts of their experiences as therapists who have had to handle patient suicides, and the difficulty of dealing with loss on two levels, the personal and the professional together. Given these difficult and emotional scenarios, it is essential that therapists have a firm sense of themselves and their feelings, whether they choose to be overtly self-revealing with their patients or maintain a more neutral stance.

Jansen (1985) argues that if a therapist is well integrated and capable of a healthy and appropriate grief reaction he/she can make an appropriate determination of how much of their personal grief to share with patients. She does warn against the possibility of patients being tempted to reverse roles and provide excessive support, question, or offer interpretations about the therapist's reaction. However, the benefits of self-disclosure is found in patients being able to see the therapist as a genuine human being who shares in problems of life and loss. She points out that this can lead to increased growth in the patient, to accept personal limitations, and feel less threatened by genuine emotional reactions generally. The therapist may then be able to function as a role model for appropriate ways of dealing with intrapsychic conflicts, helping patients experience and accept a range of human emotions, as well as learn about appropriate behavioral responses to loss of significant others. Ultimately, she points to the possibility for increased self-confidence and self-esteem for the patient through the therapist self-disclosures, but also warns for the necessity of the therapist to accurately assess for themselves the motivation behind their decision to information patients of their own loss.

An example of one therapist's disclosure about the loss of his newborn son, emphasizes how sharing with parents helped diminish anxiety and elicit a freer rapport between patients and therapist. He writes:

> Disclosure and openness offer the parent permission to see, to feel, to touch his/her wounds, and thus to mourn. This stance suggests that the author, having lived it, will not be overwhelmed by the anxiety provoked by a perinatal death so that "crazy" thoughts, feelings, wishes, impulses, etc. can be expressed . . . . Through analytically oriented and most comfortable with being a reasonably neutral object onto which patients project, in the situation of my research and several therapies since, for me it would have felt unauthentic not to disclose. Acknowledgement of personal experience seemed not an intrusion or countertransference manifestation, but a bridge to genuine relatedness. (Peddicord, 1990, p. 271)

Goldberg (1986) stresses the importance that psychotherapists pursue the examined life, and emphasizes that this is especially relevant when one is practitioners to remain vulnerable and open to all feelings in their patients, in order to be most responsive and available to client's communications. This approach echoes the concept of "internal supervision" proposed by Casement (1991), in which an analyst might attempt to look at themselves as a patient might see them, or use projective identification as a means of communication, as when for instance, the analyst may feel himself being moved to tears as a projection of a patient's unacknowledged losses.

It is apparent that some self-disclosures can be helpful, and some may be unnecessary; some may be appropriate, and some never appropriate. The evidence from this survey emphasizes the need for self-disclosure to be used judiciously, but that in being well-timed and in a balanced manner, self-disclosure can be a powerful therapy tool.

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS

This study was initiated in order to contribute to an understanding of the psychosocial process of the grief therapist. As the question "who is the grief therapist?" is explored, it appears that the answer lies in an appreciation of the therapist as a total person, and their development of a sense of self. The focus is appropriately first on the person, and their role as therapist second. The process that unfolds points to a culmination of life experiences, personal qualities and interrelationships. The basic psychosocial process which resulted from this study involves the sense of the grief therapist as evolving a sense of self.

Three influences appear to combine and interact in this process. The first is the therapist as an "acquiring self," through such "external influences" as their relationship with significant others (family, friends, mentors), various critical incidences (losses, changes, various developmental markers), education, and life experiences which have influenced their maturity.

Connected closely with the "acquiring self" is the "integrating self," which consists of the internalized influences (personality, philosophies, self-reflection), and the beginnings of a "therapist identity," identifying with, reflecting, connecting, and comparing themselves with the experience of the patient.

An important interaction takes place in the therapy session: here, the therapist allows himself or herself to be "used by the patient" in a special way.

As the patient works through their grief, the therapist begins to develop deeper connections with the patients, often recalling similar experiences from his or her own life, looking for parallels and insights that will help them relate to the patient, focusing on "being present" to the patient, with the essential empathy and rapport, allowing himself/herself to hear and be affected by the patient's "life story" or description of the loss experience, interpreting and questioning, risking and taking chances with interpretation, and generally working in a collaborative effort with the patient. During this phase, various countertransference issues may arise, based on unresolved issues by the therapist: projections of anger, helplessness, or hopelessness are common although the therapists attempts to maintain a professional stance of empathy, yet always cognizant of the necessary therapeutic boundaries. Ultimately the therapist "learns from the patient" (Casement, 1991). By using his/her own skills and experiences to better understand the patient, the therapist comes to better understand the patient but also himself or herself as a person.

As the relationship unfolds in the process of therapy, the therapist begins to experience a sense of personal growth, termed in this discussion the "emerging self." Therapists speak about a newly acquired self-awareness that has come from the culmination of their past experiences and their emotional contact with the patient. Thus, therapists speak of concepts such as seeing life as a flow, between past, present and future; an awareness of "reintegrating" their insights about themselves and life to a new level; increased trust in their perceptions; and self-valuing. It is clearly evident from the cases in this study that the "emerging self" is one who can not only be self-reflecting, but self-revealing, and uses self-disclosure to further enhance self-awareness. Grief therapists portray themselves as especially able to make connections with their patients. Often this was revealed by examples of them actually sharing personal experiences; if not always overtly expressed, it was nevertheless apparent that the therapist was very keenly aware of their own losses and experiences, as they related to their patients, and perhaps were reliving the experience internally.

"Self" disclosure implies the distinct use of the self, both in therapy, and in one's life. Grief therapists are seen as on the whole having the courage to risk self-revelation, and thereby be known by others in a more intimate way. It appears that the ability to self-disclose helps solidify relationships, and enhance a process of "change" which involves feeling closely connected to others, and with a new-found sense of value for oneself. Thus, in this process, the therapist appears to emerge with an increased awareness about life. Ultimately, grief therapists experience an evolving sense of self. They are people who have reflected on their losses, had an intense and compassionate interaction with their patients, and emerged with an increased awareness about themselves, and the value of life. This study reveals that despite the stresses and the challenges of grief therapy, the grief therapist is someone who is sensitive to people's pain, respectful of people's experience, and willing to open themselves up to new experiences and relatedness to their patients. They let themselves be "used" as empathic listeners, offer confronting and supportive interpretations, and see themselves as fellow humans who also know about suffering. The end result is a portrayal of an individual who is not afraid to directly confront death, but a person who very much lives, values and respects all aspects of life.

Further Research and Implications

This study was limited to individuals who had at some point in their professional career demonstrated interest and competence in the area of working with grief patients. A future longitudinal study may focus more on therapists, or perhaps aging therapists, who have dedicated themselves solely to this particular area of pursuit, and perhaps offer an opportunity to further investigate their experiences as grief therapists.

This study focused only on the views of the therapist about themselves. Future directions may turn to discovering how patients in grief therapy experience their therapist.

A comparison of grief therapists and their various philosophical and theoretical orientations may be compared for their effectiveness.

The generalizability of the model for grief therapists may be considered for other areas of therapy such as individual therapy, marital therapy, or family therapy.

Further in-depth studies of therapist personality characteristics and critical incidents may be explored for salient factors of the making of an effective grief therapist.

Epilogue

As this study unfolded, I found myself going through a similar process as the therapists I interviewed. I recognized in myself the phases of my development as a therapist, influenced first by an acquired sense of self based on external influences from various losses and experiences. Numerous internal aspects have become integrated in order for me to achieve my sense of self as a therapist. I have also recognized my awareness of myself in relationship to my patients, using myself in the therapy sessions, ultimately allowing my interaction with others to affect and change me.

I found myself re-examining the salient influences in my life, and the factors that have contributed to myself as a therapist, and as a person. The centrality of self-disclosure which became highlighted in the interviews, offered a particular challenge to me, as my training in the psychodynamic perspective, discouraged overt self-revelation with patients. I found myself experiencing great resistance to the possibility of people learning about my personal vulnerabilities. The entire procedure of writing this thesis became an internalized conflict regarding how much I could reveal about myself as a person. I received much inspiration from the therapists I interviewed. Their candidness and honesty set a high precedence for me to not only acknowledge, but also to reveal, how certain events had influenced my life. This discussion offers me an opportunity to put into place what the grief therapists in this study have taught me: to focus on and personally acknowledge how one of the crucial influences in my life has affected me. Thus, I have chosen to share some of my thoughts regarding the effect of my psychoanalyst's death on my life.

He passed away on April 8, 1990. I had been in psychoanalysis for several years, preparing myself for a career as a therapist, and ultimately through the years also embarking on a personal journey of self-discovery. I did not know then, and did not find out until after his death, that the theme of loss was underlying our entire relationship, for shortly before I met my analyst, he had been diagnosed with a serious fatal illness.

One of the aspects that my therapy took on was a sense of denial about death. While I think my analyst had also not fully faced the fact of his impending death, it was particularly easy for me to collude with this denial. One of the most obvious manifestations of my own denial about death occurred when in the fall of 1987, my father died, after a lengthy illness. I thought, at that time, that I was dealing with my feelings about this first major loss in my life, but looking back now, I see how much I had buried my feelings, perhaps clinging to the transference relationship with my analyst as a defense against the realization that one of the dearest people to me was gone forever. I found myself suppressing my feelings in excessive activity, particularly around my work and studies.

Looking back now, I can see more clearly the various signs that helped me realize that at least at some unconscious level, I was anticipating further loss. I recall dreams where my analyst was portrayed as having a cancerous growth on his leg, which he was trying to cover up. Other dreams involved visiting his home/office, only to find it empty. Together, it became clear that I never fully explored the intricacies of these dreams, and thus never discussed at length or faced the fact that someday he too would be gone.

I found myself often feeling protective of his feelings, monitoring my feelings when I felt excessive rage regarding his gradual withdrawal and emotional distancing. I interpreted these feelings as particularly significant to my dynamics, recalling earlier losses in my life and feelings of abandonment. I also kept many feelings contained, sensing intuitively that my analyst was not well, and not wishing to add to his stress. At the same time, when questions did arise, or concern for him was indicated, his tendency to turn the issues back on to me, added to my feelings of self-doubt. When I noticed that he was looking tired, losing weight, and falling asleep in my sessions, I found myself blaming myself for not being a "good patient" who could keep him active and interested. At no time was there a clear admission on my part that "something" was changing. The idea of death was rarely mentioned, and when it was, I felt guilty.

I found myself feeling a sense of responsibility to be supportive and positive. I would later recognize the urgency and the tenacity with which my analyst clung to the pace of his practice, and the constant energy and motivation he seemed to receive from his patients. Sometimes I felt we reversed roles, and that I was there to help him. All this was experienced at an unconscious level, however, and could only be brought more clearly into view after the fact.

As I reflect on the relationship, I recognize how much I would have appreciated feeling more informed about the facts of his illness, and even about his feelings. I wish he would have disclosed more. I feel I missed an opportunity to work through feelings about my own death. I also spent much time doubting my own feelings, only to realize later that my perceptions had been accurate all along. I missed a chance to truly terminate my analysis, and say good-bye to him, and to our relationship. His death was sudden for me, and though I did have an opportunity to say a final farewell, even then, I found myself clinging to the hope that this could not truly be the end. I found the "closure" aspect of self-disclosure difficult to attain.

My experience of losing an analyst to death has helped me greater appreciate the influence he had on my life. I remember him as active and vibrant, a dynamic individual, who gave so much of himself in my therapy. It is unfortunate that regarding the topic of death, he chose not to, or perhaps could not share more. But I can see he shared the most important insight after all–that we are all human and thereby vulnerable. Thus, even in his death, he taught me about life, and about myself. I am forever grateful for having had the privilege to know him.

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APPENDIX A

BACKGROUND INFORMATION

BACKGROUND INFORMATION

Please complete the following:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Age: ______________________________

Occupation: ______________________________

Education: ______________________________

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Clinical Experience: ______________________________

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Other Background Information: ______________________________

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APPENDIX B

SAMPLE QUESTIONS

SAMPLE QUESTIONS

1. Tell me about your experiences as a grief therapist?
2. What incidents, both professional and personal, would you describe as outstanding markers in your development and identity as a grief therapist?
3. What personal qualities have you developed or found to be most valuable in your work?
4. What personal influences would you say have made the most impact on your work as a therapist?
5. What experiences stand out as highlights in your career?
6. As a therapist, how is grief therapy unique or different?
7. What events do you see you interpreted differently than your clients?
8. What mistakes have you made in relation to being a grief therapist?

9. What have been the most meaningful events that have taken place either in your personal life or in the therapy situation?

10. How have you grown as a person in being a grief therapist? What events have lead to your growth?

11. In what ways are you able to identify with your patients?

12. In what way have you attempted to adjust to your losses?

13. How has your psychotherapeutic practice affected you as a person and the choices you have made?

14. What losses have you experienced in your life? Do they appear to have influenced your work or how you view yourself as a therapist and as an individual?

15. How would you describe yourself as a person and a therapist?

APPENDIX C

CONSENT TO PARTICIPATE

CONSENT TO PARTICIPATE

I agree to participate in the following:

> a research study concerned with understanding the personal and professional experiences and qualities of grief therapists. As a participant, I will be interviewed and asked to describe my experiences and feelings, both as a therapist and a person.

This research study, conducted by Sandra Dmytrash of the University of Alberta, Faculty of Graduate Studies, Department of Educational Psychology has been explained to me. I understand the purpose of this study. I also understand that these interviews will be recorded on audio-tape. Audio-tapes will be erased after the completion of the study. Upon my request, I will receive feedback about the study outcome when it is completed as well as a copy of the transcribed interview. Any questions I have about the study will be answered by Sandra Dmytrash. All information is confidential and my identity as well as anyone I mention will not be revealed. My participation is voluntary and I can discontinue my participation in this study at any time.

On the basis of the above statement, I, ______________________________
agree to participate in the above study.

SIGNED ______________________________ DATE __________________

WITNESSED ____________________________ DATE __________________